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# OUTPATIENT PATIENT INFORMATION SHEET

## Patient Information

**Patient Name:** _____ Sex: ☐ M ☐ F
Last First Middle

Child's Social Security #: _____ **DOB:** _____ Religion: _____

Parent/Legal Guardian: _____ Relationship: _____ SS#: _____

Parent/Legal Guardian: _____ Relationship: _____ SS#: _____

Address: _____
Street City State Zip

Referred by: _____ Phone #: _____

Address: _____
Street City State Zip

Primary Care Physician: _____ Phone #: _____

Physician Address: _____ Fax #: _____
Street City State Zip

***Ethnicity**: Hispanic/Latino Origin: ☐ **Y** ☐ **N**

***Race** (circle one): American Indian or Alaska Native; Asian; Black or African American; White; Hispanic or Latino; Native Hawaiian/Other Pacific Islander;

Other _____ ***Required by Title 25, Texas Administrative Code, Chapter 1301.19 © (1-2)**

## ALLERGIES

Food/Environmental Allergies? ____ No ____ Yes If yes, please list here or attach list:

_____

_____

_____

Medication Allergies? ____ No ____ Yes If yes, please list here or attach list:

_____

_____

_____

## Medication Profile (attach list if necessary)

| Medication Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*I understand that it is my responsibility to provide updated information to Our Children's House at Baylor on any changes in my child's medications and/or allergies. If I fail to provide this information in a timely manner, I hereby release Our Children's House at Baylor from any and all liability on information that has become inaccurate.*

_____ _____
**Signature of Parent/Caregiver** Date

Therapists Initials: _____ _____ _____ _____ _____ _____ _____

# OUTPATIENT PATIENT INFORMATION SHEET

## PATIENT PREFERENCE REGARDING COMMUNICATION OF HEALTH INFORMATION

### I. How to Contact

**I wish to be contacted in the following manner:**

Home Telephone #:_____
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

Work Telephone #:_____
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

Cell Phone #: _____
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

Day Time Telephone #:_____
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

**Written Communication**

☐ OK to mail to my home address _____
☐ OK to mail to my work/office address _____
☐ OK to fax to this number _____
☐ OK to e-mail (for appointment reminder only) to: _____

### II. Who to Contact

I hereby give permission to Our Children's House at Baylor to disclose and discuss any information related to my child's therapy session(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ **I do not wish to disclose any information with anyone.**
Initial

### III. Who to Release Child To

Your child will not be released to any person(s) whose name does not appear on this form. NO verbal authorizations will be permitted. If names are to be added or deleted to this list, please do so in writing. The staff of OCH reserves the right to ask any individual to show proper identification. This is for the protection of your child(ren). I hereby give permission to Our Children's House at Baylor to release my child, in my absence, to the following list of people:

**Same as above** ☐ **Yes** ☐ **No**

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
**Signature of Parent/Caregiver** Date

Therapists Initials: _____ _____ _____ _____ _____ _____ _____

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# OUTPATIENT PATIENT INFORMATION SHEET

## Accident Information

Is this admission related to an accident? ____ No ____ Yes If yes complete the following questions.

Date of accident _____ Time accident occurred _____

Location of accident including the County: _____

Description of accident: _____

_____

## Primary Commercial Insurance

Insured: _____ SS/ID #: _____ D.O.B.: _____

Relationship to Child: _____ Home Phone #: _____ Work Phone #: _____

Insurance Company: _____ Group # _____

Employer: _____

Employer Address: _____

_____

(Please bring your card with you so that we can make a copy for your child's file.)

## Secondary Commercial Insurance

Insured: _____ SS/ID #: _____ D.O.B.: _____

Relationship to Child: _____ Home Phone #: _____ Work Phone #: _____

Insurance Company: _____ Group # _____

Employer: _____

Employer Address: _____

_____

(Please bring your card with you so that we can make a copy for your child's file.)

## Medicaid

Child's name as it appears on their card: _____

Name of plan (circle one): Traditional PCCM Amerigroup Amerigroup CHIPS Parkland Parkland CHIPS/Kidsfirst Unicare Unicare CHIPS Aetna CHIPS Superior

ID #: _____

(Please bring your card with you so that we can make a copy for your child's file.)

****Please note that we must obtain authorization for therapy visits for your child with Medicaid.** Each plan requires their own separate authorization. Therefore, each time that your child changes from one plan to another, it will result in therapy visits being stopped until a new authorization is received. This process can take anywhere from a few days to a couple of weeks depending on timely response from your child's physician and the plan itself.

_____ _____

**Signature of Parent/Caregiver** Date

# OUTPATIENT PATIENT INFORMATION SHEET

## Health History

Does your child have any medical conditions related to the following:

| | | | | | |
|---|---|---|---|---|---|
| Heart | ___ No | ___ Yes | Seizure | ___ No | ___ Yes |
| Lungs | ___ No | ___ Yes | Arthritis | ___ No | ___ Yes |
| Kidneys | ___ No | ___ Yes | Diabetes | ___ No | ___ Yes |
| Digestive System | ___ No | ___ Yes | Cancer | ___ No | ___ Yes |
| Surgery | ___ No | ___ Yes | High Blood Pressure | ___ No | ___ Yes |
| Bone/Joint Injuries | ___ No | ___ Yes | Difficulty Eating | ___ No | ___ Yes |
| CMV | ___ No | ___ Yes | | | |

If "Yes," please explain: _____

_____

Does your child have any other medical conditions, contagious or otherwise, that we should know about? ___ No ___ Yes

If "Yes," please explain: _____

_____

Current Weight _____ Height _____ Head Circumference _____

Has child had **unintentional** weight gain or loss of more than 5 lbs. in last 12 months? ___ No ___ Yes

If so please describe: _____

## Surgeries / Procedures

| Date | Procedure | Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Pain Assessment

Is your child having Pain/Discomfort now or experienced pain recently? ___ No ___ Yes

If "Yes," please answer the following questions:

Where is the pain located? _____

When did the pain start? _____

Is the pain constant or intermittent? _____

Any other associated symptoms? _____

What makes the pain better? _____

What makes the pain worse? _____

Has child experienced this pain before? ___ No ___ Yes

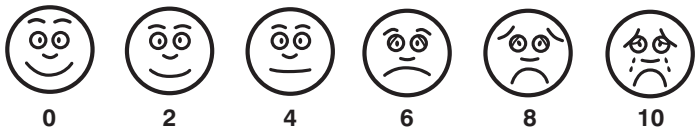
What treatments have you been using _____

Is this pain affecting daily activities? ___ No ___ Yes

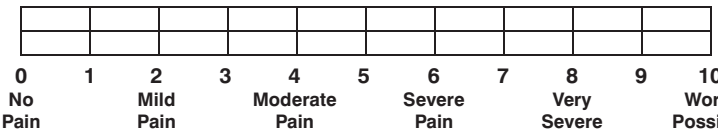
Is the level of pain acceptable? ___ No ___ Yes

Overall Pain Level

(Please circle the most appropriate number under the smiley faces in the picture.)




**0-10 Numeric Pain Intensity Scale**




Therapists Initials: _____ _____ _____ _____ _____ _____ _____

# OUTPATIENT PATIENT INFORMATION SHEET

## Learning/Cultural Needs

Age group of patient: (Please circle one.)

| Infancy (Birth-1 yr) | Toddler (1-3 yrs) | Pre-School (3-6 yrs) | School Age (6-12 yrs) | Adolescence (13-18 yrs) |
|---|---|---|---|---|

Name of school your child attends _____

Is there another person who needs instructions of your child's treatment in addition to yourself? ___No ___Yes

If so: _____
Name Relationship

What languages are spoken in child's home? _____, _____

How do you and your child learn best? Mark "X" for all that apply.

| | Verbal Instructions | Written Instructions | Demonstration | Practice |
|---|---|---|---|---|
| You | | | | |
| Your Child | | | | |

Are there factors which would affect you and your child's ability to learn? Please mark "X" in boxes which apply.

| | You | Your Child | | You | Your Child |
|---|---|---|---|---|---|
| Hearing | | | Memory Loss | | |
| Reading | | | Comprehension | | |
| Writing | | | Religious | | |
| Vision | | | Cultural | | |
| Pain | | | Language | | |
| Stress | | | Interpreter Needed? | | |
| Limited Attention Span | | | | | |

Are there any religious/cultural practices we should know about that could better help us take care of your child? ___ No ___ Yes

If so, tell us about it: _____

_____

_____

Therapists Initials: _____ _____ _____ _____ _____ _____ _____

# OUTPATIENT PATIENT INFORMATION SHEET

## Communicable Disease/Immunization Screen

Please indicate if your child's immunizations are up-to-date: ___ Yes ___ No
If no, please contact your primary care physician.

In addition, we need for you to understand that the health and safety of all children and staff must be protected; therefore, please understand the following:

1. Your child may not be allowed to visit or receive treatment if the child has any of the listed diseases/symptoms below.
2. These diseases could be harmful to children being treated at OCH.
3. You should let the staff know if your child is exposed to or becomes ill with any of those diseases or symptoms.

**Has your child been exposed to any of these communicable diseases or had any of these symptoms today or in the last 24 hours:**

| | | | |
|---|---|---|---|
| Diarrhea | ___ No ___ Yes | Cold Sores | ___ No ___ Yes |
| Nausea or vomiting | ___ No ___ Yes | Impetigo | ___ No ___ Yes |
| Fever | ___ No ___ Yes | Infected or draining skin sores | ___ No ___ Yes |
| Cough | ___ No ___ Yes | Rash from unknown cause | ___ No ___ Yes |
| Running Nose | ___ No ___ Yes | Pink eye | ___ No ___ Yes |
| Sore Throat | ___ No ___ Yes | Night sweats, fever, weight loss, coughing up blood | ___ No ___ Yes |
| Measles | ___ No ___ Yes | Chicken Pox | ___ No ___ Yes |
| Mumps | ___ No ___ Yes | Tuberculosis | ___ No ___ Yes |
| MRSA | ___ No ___ Yes | | |

In addition to birth, has your child ever been a patient in a hospital for a 5 day stay or longer? ___ Yes ___ No

If "Yes" was your child in "isolation"? ___ Yes ___ No

If "Yes" in what hospital was your child a patient? _____

By signing below, I certify that I have answered all questions with accurate and complete information. I understand that it is my responsibility to promptly notify Our Children's House at Baylor if I discover that any information is inaccurate or incomplete or becomes inaccurate or incomplete in the future. I hereby release Our Children's House at Baylor from all liability for any action it takes in reliance on incorrect or incomplete information given by me or in reliance on information that becomes inaccurate or incomplete in the future that I have failed to notify Our Children's House at Baylor about.

**Signature of Parent/Caregiver** _____ **Date** _____

Staff Signature _____ Initials _____ Date _____ Time _____

Staff Signature _____ Initials _____ Date _____ Time _____

Staff Signature _____ Initials _____ Date _____ Time _____

Staff Signature _____ Initials _____ Date _____ Time _____

Staff Signature _____ Initials _____ Date _____ Time _____