Southern New Hampshire Medical Center
Rehabilitation Services- Pediatrics
5 George Street., Hudson, NH 03051
Phone: 603-579-3601
FAX: 603-579-3607

Welcome:

Thank you for choosing **Southern New Hampshire Medical Center's Rehabilitation Services - Pediatrics**. We look forward to working with you and your child(ren) to provide the best rehabilitation care available. We will work hard to make sure your experience with us is a pleasant and positive one beginning with your first encounter at the front desk and not stopping until you have met your child's goals. You have the right to expect a clean facility, clinically skilled staff, and polite, pleasant interactions with all of our staff.

To make the best use of your time, we have developed this information packet. This packet contains forms for you to complete and return now. It also contains helpful answers to many frequently asked questions about therapy. Please read all of the information. If you have a question, please ask your therapist. She will be happy to explain any part of the packet.

We look forward to working with you and your child in the weeks to come. Our goal is to help your child improve their ability to function more independently in your home and in your community. It is important to remember that the therapy we provide is medically based therapy and is meant to be ***short term.*** Most children receive therapy for approximately six months. Therapy services may vary in length depending on diagnosis and severity of impairment and at the discretion of the treating therapist. At the time of discharge, the therapist may assist in transitioning to home and community based activities that will continue to encourage their growth. Goals will be set for your child and you will be updated periodically on your child's progress to help anticipate when it will be time to transition to activities in your home and community. Completion of home programs is essential in your child's progress through therapy and after discharge.

Medically based outpatient services cannot provide maintenance. Maintenance is described as the following: ***Continuation of therapy services while there is a plateau of skills and limited or no documented progress.***

Your child may need ***Episodic Care***. This means after your child is discharged, therapy may need to be started again if your child regresses or has a new diagnosis.

Again, thank you for choosing the Southern New Hampshire Medical Center where we are committed to a higher level of care. If you have any questions or concerns, please contact me directly at:

Kathy Pierce, DPT, MS, OCS
Director
Southern New Hampshire Rehabilitation
Center 17 Prospect Street
Nashua, NH 03060
603-577-3050

PEDIATRIC REHABILITATION:
GENERAL INFORMATION

SCHEDULING APPOINTMENTS

Your time is valuable, and we will make every effort to schedule appointments at a time that is convenient for you and your child. As you schedule appointments for your child, please consider the following suggestions:

- Your child will be given a **therapy appointment time** (that should remain consistent) throughout your child's need for services. It is your responsibility, however, to ensure that your child is indeed *scheduled* for his/her therapy visits.

- Once you know how often your child will need therapy, schedule as many upcoming appointments as possible. Please do not wait until your last scheduled appointment to make more appointments. We would rather cancel unused appointments than have your child miss getting the time that he/she needs. Please request a print-out copy of your child's schedule from the Front Desk staff for your records.

- If your scheduling needs change, please contact your child's therapist directly. Your request for a schedule change will be accommodated as the therapist's availability allows. If the time you have requested is not immediately available, your child may be placed on a treatment waiting list.

IF YOU CANNOT KEEP AN APPOINTMENT

- Regular attendance is essential to your child achieving the best results from his/her therapy program. If you are unable to keep an appointment, please call us with **24 hours advance notice** at (603) 579-3601. (If you miss two consecutive appointments without proper notice or have inconsistent attendance, your child's services may be suspended.)

- Please be sure to keep our office updated with home, work, and cell phone numbers and indicate the best way to reach you in the event that we need to contact you. If you would also like to be contacted by email, please provide your email address.

IMPORTANT INSURANCE INFORMATION

- Insurance coverage varies greatly. **You are responsible for knowing and understanding your insurance coverage/benefit information.** This information is usually found in your plan's Certificate of Coverage or by calling customer service. We are happy to help you to understand your child's diagnosis and need for therapy so that you are able to share that with your insurance company.

- You are responsible for paying any co-payments, co-insurance, or deductibles, depending on your insurance carrier. You may either make co-payments at each visit or weekly if you come more than once per week. If you do not make your co-payment here, you will receive a bill from Southern New Hampshire Medical Center.

- If you do not have insurance, you will receive a bill for therapy. Please contact our financial counselors if you would like to apply for financial assistance, or our collection office if you would like to make payment arrangements. The numbers are listed below:

Financial Counselor:
577-2241 or 577-2264

Budget and Payment Options - Patient's Last Name begins with:

A-C	577-7873
D-G	577-7880
H-L	577-7877
M-Q	577-7878
R-Z	577-7872

- Most insurance companies now require authorization or pre-authorization for therapy sessions (each session must be authorized). Each plan has different requirements. Some require the authorization from your primary care provider (PCP), some from your referring provider (which may be your PCP or may be a specialist such as a neurologist), and some require authorization from a review process at your insurance company.

- Tips to avoid delays in your schedule are:

  ✓ Contact your PCP and start the process early. Bring **all** the paperwork that he/she gave you.
  ✓ **Come to therapy with all insurance cards and authorization or referral numbers that you** have.
  ✓ Share all clinical information with your therapist.
  ✓ Let the Front Office Staff know if you have had a change of insurance to avoid interruptions to therapy sessions. Often, new authorizations must be obtained prior to a continuation of services.

EVALUATION REPORTS/WRITTEN DOCUMENTATION

- Evaluation reports will be sent to the individuals that you have authorized via written permission on the *Consent to Release Medical Information Form*. Please allow approximately 4 weeks for receipt of the report.

- Please notify your child's therapist **as soon as possible** if another servicing provider (e.g., primary care physician, specialist, therapist, teacher, etc.) is in need of written documentation of your child's progress and/or therapy goals. Every accommodation will be made to forward this information to the requested individual in a timely manner; however please allow at least 10 business days for this documentation to be provided. A *Consent to Release Medical Information Form* will need to be completed prior to the information being sent to the requested individual.

QUESTIONS, CONCERNS, OR COMPLIMENTS

Our promise is to provide you with the best possible service for your child, by a highly skilled professional, in a clean and comfortable setting. Our goal is to work together with you as a team to facilitate progress toward your child's goals.

We routinely survey our patients. It is one of the few methods we have to see how we are doing in meeting our patient's needs. Your opinion has an immediate and direct effect on how we serve our patients. The information has been the start of many important changes. We appreciate your participation and welcome any feedback about your family's experience with our pediatric therapy services.

Please share your thoughts with your therapist at any time. If you do not feel comfortable sharing your concerns with your therapist, you may discuss them directly with the Director of SNHRC. Please contact:

Kathleen Pierce, DPT, MS, OCS
Director – SNHRC
17 Prospect St
Nashua, NH 03060

Or Call: (603) 577-3050

If you are satisfied with our services and facility, please recommend us to others.

PEDIATRIC REHABILITATION: WORKING TOGETHER

The best way to get the most from therapy is to follow these tips:

- **Share your questions.** The more information you have, the more you can participate in your child's therapy program. It is important that you understand your child's initial evaluation and treatment plan so that you may participate in setting goals.

- **Be on time.** Because our therapists see patients consecutively, your child may have less time with his/her therapist if you are late to a session. If you are more than 10 minutes late, your appointment may be rescheduled.

- **Carry out home programs as assigned.** The therapist will design a home program for your child's specific needs. Please complete and return the homework sheets as directed if given to you by your child's therapist. This helps to determine which new activities will be included in handouts for the following week/month.

- **Practice whenever possible.** To benefit most from any type of therapy, practice is essential. Working on new skills outside of scheduled therapy time has the greatest effect on progress towards goals. As such, we strongly encourage parents to provide opportunities for their children to practice their new skills by engaging in recommended activities and try suggested strategies with their children at home and in the community. This will also help to promote generalization of skills to home and other settings.

- **Involve caregivers and family members.** You are welcome to involve your child's caregivers in therapy as you deem appropriate. Often, they can encourage and support your child's efforts during those times when you are not available.

- **Be present for therapy.** It is suggested that you make arrangements (whenever possible) for your other children so that you may participate in your child's therapy. This ensures that you know what new skills and strategies your child is learning and promotes your ability to offer support and cueing at home.

Please note: If the patient is a minor, a parent <u>must</u> be present (on the premises) during sessions.

Attendance Policy

Thank you for choosing Southern New Hampshire Medical Center Rehabilitation Services.
We look forward to working with you.
As a partner in your care, our goal is to help you meet your rehabilitation needs through a series of scheduled visits. Our attendance policy will help you understand the time needed to regain function and help you reach your goals. We ask you to agree to the following:

- Please arrive on time and check in with the receptionist. Arriving after your scheduled appointment can limit your treatment time and the treatment time of other patients.
  (If you are more than 10 minutes late, you may be asked to reschedule.)
- Kindly give at least 24 hours notice if you need to reschedule or cancel an appointment.
  (Please know that cancelled appointments may delay your recovery.)
- Two or more missed/cancelled appointments within a month shows that you are not, currently, fully engaged in your recovery and may result in your discharge until you are able to continue with therapy. If necessary, we will notify your referring provider and encourage you to speak with him or her as well. ***(We understand unusual circumstances arise, and we will accommodate them if possible.)***

At Southern New Hampshire Medical Center Rehabilitation Services we are committed to being on time for your appointments. However, on occasion, we may run behind schedule. We thank you in advance for your understanding and patience.
We are dedicated to your recovery and strive to provide you with a higher level of care. Please sign and date below to indicate your understanding of our attendance policy. Thank you.

__________________________________ Date: _________________________________
Patient Signature

__________________________________ Date: ___________________________________
Therapist Signature

Pediatric Center
5 George Street
Hudson NH 03051
Ph: 603-579-3601
Fax: 603-579-3607

PEDIATRIC THERAPIES: PT, OT, SLP

FAMILY AND MEDICAL HISTORY FORM

Please complete this history form. The information provided will help us in determining the best course of therapy your child. If you have any questions please discuss them with your child's therapist. Thank you.

General Information:

Patient's name: ____ Date of Birth: ___________________

Parents' names: ____

Who is your child's pediatrician? ____

What are your primary concerns regarding your child? ____

____

When did you first have these concerns? ____

What languages are spoken in the home and day care? ____

Email: ____

Others living in the household:

NAME	SEX/AGE	RELATIONSHIP TO CHILD	HEALTH STATUS

Family Medical History:

Is there a family history of any genetic, congenital or familial medical conditions? If so please list condition and relationship to patient (i.e. autism, muscular dystrophy, ADD/ADHD, cardiac, respiratory or gastrointestinal issues)

____

____

____

____

____

____

Prenatal History:

Were there any medical conditions or events during the pregnancy for this patient? If yes please explain (what month, why, what, occurred, how treated, etc):____

____

____

____

Labor, Delivery and Birth History (for this patient):

Length of pregnancy: ______________________ Length of Labor (in hours): ______________________

Any type of labor stimulation, and what was used? ____

What type of delivery (please circle) Vaginal C-section Reason for C-section ________________________________

Were there any issues with the cord? Please circle: knots, prolapsed, compressed, baby had cord around neck

Were there any other problems during the labor/delivery/birth? ______________________________________

Was fetal distress, very low or high heart rate, or heart rate decelerations noted? If yes, please circle all that applied

What were the baby's APGAR scores? 1 minute ___________________ 5 minutes _________________________

What was the baby's birth weight? ___________________ Length? ____

Number of Days spent in the nursery: ________________ NICU or Newborn Nursery? ______________________

Did the patient have any of the listed issues during his or her Birth hospital stay? Please indicate by placing a checkmark in the fist column and explain (what month, why, what, what occurred, how treated etc). Please use the reverse side if more space is needed.

YES	DESCRIPTION	EXPLANATION
	Was blue/cyanotic at birth	
	Required stimulation to breathe/ventilation	What type/ howlong?
	Required oxygen at birth	How much/what type?
	Required resuscitation	
	Was considered small for gestational age	
	Had tremoring or seizures	Which/for how long?
	Very low tone	
	Brain hemorrhage	
	Anemia and/or transfusions	Which/how many times?
	Jaundice (yellow)	How much/how treated?
	Infections	

	Congenital birth defects	
	Aspiration (meconium or fluid)	Which/how treated?
	Respiratory distress signs or syndrome	
	Choking or vomiting episodes	
	Tube feedings	
	Needed medications	

Nutritional History:

Describe your child's feedings briefly from birth, noting any difficulties (breast/bottle fed, colic/food allergies, introduced solids/table foods, growth/nutrition problems, feeding problems) ____

____

____

____

Did/Does your child use a pacifier or suck thumb or fingers?____

Does your child drink from a cup? Please specify what type (i.e., spout cup, straw cup, open cup, sports bottle): ________

____

Does your child eat a variety of textured foods (i.e., smooth, lumpy, crunchy, chewy, etc.)? Please specify food types:____

____

What type of utensils does your child use to feed him/herself? ____

Medical History of the Child:

It is very important to have as complete a medical history for your child as possible. Please check the first column if your child has experienced any of these conditions, include an explanation for any question answered "yes." In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

YES	DESCRIPTION	EXPLANATION
	Frequent Colds/Respiratory Illness	
	Frequent Strep throat/sore throat	
	Tonsil and or adenoid removal	
	Frequent Ear Infections	
	Hearing Loss/Ear disorder	
	Myringotomy tube placement	
	Lung condition/respiratory disorder	

	Heart condition	
	Anemia/blood disorder	
	Kidney /Urinary problems/infections	
	Muscle disorder/muscle problem	
	Joint or bone problems/Fractured bones	
	Skin disorder/skin problems (eczema)	
	Vision problems/Eye infections	
	Neurological disorder	
	Seizures or convulsions	
	Stomach disorder/stomach pain	
	Vomiting/digestion problems	
	Failure to gain weight/feeding problems	
	Constipation/diarrhea problems	
	Dehydration episodes	
	Head injuries or concussions	
	Ingestion of toxins, poisons, foreign objects	
	Any communicable diseases (CMV, MRSA, HIV, etc)	
	Any major childhood illness (pox, croup, measles, mumps, meningitis, Fifth's disease, etc)	

<u>Hospitalizations, Surgeries and/or Accidents:</u>

List the dates of any hospitalizations, surgeries, and/or accidents your child has had and the reason: ___________________

____

____

Please note any illnesses for which your child is currently being treated, **including medications**: _____________________

____

____

Does your child have any known allergies? If so, please list:____

____

Motor Developmental History:

We would like to have information about your child's developmental milestones. Please indicate when your child first did each of the following INDEPENDENTLY by checking in the appropriate box of on time or late as appropriate. If your child has not yet achieved the milestone, write N/A in the age column.

MILESTONE	On time (age range)	Late	MILESTONE	On time (age range)	Late
Smiled	≤ 2 mos		Threw objects actively	≤ 16 mos	
Held head up sitting	≤ 3-5 mos		Ate independently with a spoon/fork	≤ 2.3 years	
Rolled both ways	≤ 6 mos		Dressed self	≤ 4 years	
Reached for an object actively	≤ 5 mos		Caught a thrown object	≤ 26 mos	
Transferred object between hands	≤ 7 mos		Demonstrated handedness (which?)	≤ 5.5 years	
Sat unsupported	≤ 9 mos		Rode bicycle without training wheels	≤ 9 years	
Crawled	≤ 10 mos				
Stood alone	≤ 13 mos		Bladder trained - days	≤ 3 years	
Walked independently	≤ 15 mos		Bladder trained - nights	≤ 3 years	
Ran	≤ 18 mos		Bowel trained	≤ 3 years	

Hearing Testing:

Do you feel that your child hears adequately? ____

Has your child had a hearing screening? If so, when and where____

Has your child had a hearing evaluation by an audiologist? If so, please specify when and where:_____________________

What were the results? ____

Speech and Language Milestones

MILESTONE	On Time (age range)	Late	EXAMPLE
Babble	≤ 4-6 mos		
Gesture/Signs	≤ 9-12 mos		
Jargon/Jibber-jabber	≤ 12-15 mos		
Imitates sounds/words	≤ 9-12 mos		
Participates in song/finger plays	≤ 9-12 mos		
Said first word (please give an example *other than Mama/Dada*)	≤ 7 mos		
Combined 2 words together	≤ 2 yrs		
Combined 3+ words together	≤ 2 ½- 3yrs		
Followed single-step directions	≤ 12-15 mos		
Followed multi-step directions	≤ 21- 24 mos		
Knew body parts	≤ 15-18 mos		

Please describe your child's current play skills: ____

____

____

How does your child interact socially? ____

____

Does your child have opportunities to play with other children? (Please give examples)________________

____

How does your child get your attention? ____

Does your child maintain eye contact when interacting with individuals? It not, please explain:. ____________

____

Does your child point with his/her index finger to share an experience or to comment on what he/she sees? ________

____

Do you feel your child has (or has had) more or less difficulties than his/her peers in any other way? Please explain _____

____

____

Behavioral Presentation: **Circle the traits that describe your child as an infant**:

Cried a lot	Fussy	Irritable	Non-demanding	Alert	Quiet
Passive	Active	Liked being held	Resisted being held	"Floppy"	Tense
Good sleeping pattern		Irregular sleeping patterns			

Other descriptions or information regarding your child as an infant:________________________________

____

Circle the traits that describe your child currently:

Cries a lot	Drooling
Fussy	Nervous habits
Irritable	Breath holding
Quiet	Aggression
Hyperactive	Destructiveness
Lethargic	Masturbation
Easily distracted	Cruelty to animals
Attentive	Major mood swings
Keeps to self	Good sleeping patterns
Cautious with new people	Irregular sleeping patterns
Social/Outgoing	Bed wetting
Head banging	
Frequent temper tantrums	
Thumb sucking	

Please describe your child's current personality:____

How long can your child attend to activities? (Please give examples)______________________________

____

Educational Background:

Name of current school/daycare: ______________________________Grade: __________

Address: ______________________________ Phone: ______________________________

Teacher:____

Describe any other concerns shared by current teacher: ______________________________

____

Has your child ever received special education services or Early Intervention?______________________

Has there been previous testing or IEP? Yes/ No If yes please attach

If so how old was your child?_______What grade(s)?__________________

Please note if your child has a diagnosis of any type of learning disability: __________________________

What are your child's strengths? ____

____

Please indicate if any of the following services were recommended and the frequency of service (how often your child sees specialists during the school day for the following):

Speech Language Therapy ____

Occupational Therapy ____

Physical Therapy ____

Counseling ____

Behavioral Programming ____

If your child is in school, please describe any particular strengths or difficulties with reading, writing, or spelling:________

____

____

Please list any other services or Specialists your child currently is followed by:

Name Location Date treatment began Date treatment ended

____

____

____

____

To the best of my knowledge, this information that I have provided is accurate and complete.

______________________________________ ____________________

Signature of Parent or Guardian **Date**

______________________________________ ____________________

Therapist Signature **Date**

AD0031