Southern New Hampshire Rehabilitation Services

Pediatric Center
5 George St., Hudson, NH 03051
Phone: 603-579-3601
Fax: 603-579-3607

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 Street
Nashua, NH 03060

Or Call: (603) 594-6055

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

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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 must be present (on the premises) during sessions.

Southern New Hampshire Rehabilitation Services

Attendance Policy

We at Southern New Hampshire Rehabilitation Center tailor the frequency and duration of your treatment to meet your specific rehabilitation needs and goals. Your consistent attendance of the planned treatment regimen is important for your full recovery. We strive to provide patients with a higher level of care by scheduling an appointment for each patient. Cancellations, especially last minute ones, along with patient no-shows, jeopardize your recovery and decrease our ability to provide one on one care to you and our other patients.

Every effort is made to keep on schedule so we respectfully ask patients to be prompt and to keep their appointments. Our clinic's policy regarding appointments is as follows:

- We remind patients of their appointments two days in advance with an automated reminder call. An appointment list is also printed at the time of scheduling and given to you.
- If you need to change or cancel your appointment, we request at least 24 hours notice.
- If you accumulate 2 no-shows and/or cancellations, your therapist may refer you back to your physician before scheduling another appointment, allow only same day appointments, or may choose to discharge you from therapy and report this to your physician/provider.
- It is your responsibility to inform the Front Desk Staff if you arrive late for a scheduled appointment. If you arrive more than 10 minutes late your appointment may be rescheduled, and will be considered an absence.

The satisfaction of all of our patients is important to us. We thank you in advance for your cooperation with this attendance policy.

I understand and agree to comply with the above attendance policy.

Name:_____Date:_____

Staff:_____Date:_____ ___

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PEDIATRIC THERAPIES: PT, OT, SLP

FAMILY AND MEDICAL HISTORY FORM

Thank you for your time in completing this packet. This information will help us to develop a plan of care that is appropriate for you and your child.

General Information:

Child's name: _____ Date of Birth: _____

Parents' names: _____

Home Address: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone(s) #: _____ Email: _____

Reason for referral: _____

_____

Who referred your child for this evaluation? _____

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 or day care? _____

Other services your child receives: _____

_____

Other specialists who have seen your child: _____

_____

What do you see as your child's strengths? _____

_____

How would you describe your child's personality? _____

_____

_____

Others living in the household:

NAME SEX/AGE RELATIONSHIP TO CHILD HEALTH STATUS

Family Medical History:

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER, and explain WHO this is in relation to the CHILD. Please explain if medications, surgery or hospitalizations were needed. Please use reverse side if more space is needed.

NO	YES	DESCRIPTION	M or F	WHO?	EXPLANATION
		Birth defects/Congenital disorder			
		Neurological disorder or seizures			
		Respiratory disease or tuberculosis			
		Hormonal or Gland disorder			
		Allergies - food or environmental (specify which for whom)			
		Diabetes			
		Stomach disease/disorder/problems			
		Problem with senses (e.g., vision, hearing, touch, taste, smell, balance)			
		Swallowing or feeding problems			
		Attention/learning problems			
		Hyperactivity			
		Alcohol/drug problems			
		Psychological/nervous issues			
		Other			

Prenatal History:

Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

NO	YES	DESCRIPTION	EXPLANATION
		Allergies or asthma	
		Anemia	
		Diabetes/blood sugar problems	
		Edema (swelling, water retention)	
		Excessive vomiting	
		Headaches/migraines	
		Heart disease	
		Kidney disease	
		Pre-eclampsia	
		Rh negative	
		Toxemia	
		Toxin exposure	
		Accidents	
		Bleeding/spotting	
		Blood transfusions	
		Cervical incompetence	
		Infections (bladder or genital)	
		Infections (other)	
		Pre-term labor	
		Uterine or uterine fluid problems	
		Other physical injury	
		Other not specified problem	
		Use of medications (over the counter and prescribed)	

Birth History (for the child being evaluated):

Hospital where born (city/state): _____

Physician's Name: _____

Length of pregnancy: _____

Length of Labor (in hours): _____ Length of membrane rupture: _____

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

Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief _____ Anti-vomiting _____

Sedation _____ Anesthesia _____

What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency

Presentation: Head, Face, Breech, Transverse Reason for C-section _____

Assistance: Forceps, Vacuum, other _____

Labor and Delivery

Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

NO	YES	DESCRIPTION	EXPLANATION
		MATERNAL infection	
		Low/high red/white blood cell count	
		Pelvis or cervical problems	
		Placenta problems	
		Dysfunctional labor	
		Baby had the cord around the neck	
		Cord problems (knots, prolapsed, compression)	
		Baby had very low or high heart rate	
		Baby had heart rate decelerations	
		Fetal distress was noted	
		Meconium was noted	

How soon after the delivery did you see your baby? _____

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? _____

What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc). Please use the reverse side if more space is needed.

NO	YES	DESCRIPTION	EXPLANATION
		Was blue/cyanotic at birth	
		Required stimulation to breathe	
		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?
		Had bruising	
		Rh incompatibility problems	
		Infections	
		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/how treated?
		Respiratory distress signs or syndrome	
		Needed ventilation	What type/how long?
		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? _____

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 fill out the grid below, making sure you 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.

NO	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	
		Birth defect/genetic disorder	
		Lung condition/respiratory disorder	
		Allergies or asthma	
		Heart condition	
		Anemia/blood disorder	

NO	YES	DESCRIPTION	EXPLANATION
		Kidney/Renal disorder/Urinary problems/infections	
		Hormonal problem	
		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)	

Hospitalizations, Surgeries and/or Accidents:

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**: _____

_____

_____

Motor Developmental History:

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you cannot remember a specific age, please indicate whether you believe your child accomplished the milestone early, on time, or late. 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? When and where?: _____

Has you 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	Attentive	Aggression
Fussy	Outgoing	Destructiveness
Irritable	Keeps to self	Masturbation
Non-demanding	Cautious with new people	Fire play
Alert	Social	Cruelty to animals
Quiet	Head banging	Major mood swings
Passive	Frequent temper tantrums	Good sleeping patterns
Active	Thumb sucking	Irregular sleeping patterns
Hyperactive	Drooling	Bed wetting
Lethargic	Nervous habits	
Easily distracted	Breath holding	

Please describe your child currently:_____

_____

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?_____

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

_____

How old was your child when he/she first participated in a special education evaluation with the school? What grade?

_____

Was your child found eligible for services? _____

If so, 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 the specialist, the focus of intervention, and if we may contact him/her with questions.

Providers currently involved in your child's care? (including Medical & School providers):

Name	Location	Date treatment began	Date treatment ended

Name of previously attended school(s) and which grade(s) :_____

_____

Please share any other information you would like us to know about your child.

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**