

Institute for Child Development (ICD) Parent Questionnaire (PQ) - Ages 0 - 4

We're dedicated to providing thorough evaluations for children facing developmental or behavioral challenges. Your involvement is crucial to this process.

To schedule an appointment, please complete the following:

Parent/Guardian Responsibilities (for children younger than 3):

1. Complete the Parent Questionnaire, POSI, and CSBS.
2. Sign the Authorization to Use or Disclose Protected Health Information form.
3. Email us copies of Early Intervention Evaluations/ Family Service Plans (if applicable).

Parent/Guardian Responsibilities (for children ages 3 to 4):

1. Complete the Parent Questionnaire.
2. Complete the ADHD Rating Scale.
3. Sign the Authorization to Use or Disclose Protected Health Information form.
4. Email us copies of Child Study Team Evaluations and IEPs (if applicable).
5. Email us copies of prior developmental, psychological, psychiatric, and/or neurological evaluations (if applicable).

Child's Pediatrician Responsibilities:

1. Complete the attached Referral Form.

Child's Teacher / Therapist Responsibilities:

1. Complete the ADHD Rating Scale.
2. Complete the Teacher/Therapist Remarks Form.

Please send the completed documents to our Intake team:

Email: instituteforchilddev@hmn.org

Fax: **551-996-5034**

Note that our staff may request additional information at their discretion.

What happens next?

- Confirmation: Our Intake team will contact you within 3-5 business days to confirm receipt of your documents.
- Waitlist: Once **all** required documents are received and reviewed for completeness, your child will be placed on our waitlist.
- Scheduling: We will contact you once an appointment becomes available.

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

INSURANCE: Please attach a copy of the front and back of your insurance card(s)

Primary Insurance _____	Secondary Insurance _____
Policy ID / Member # _____	Policy ID / Member # _____
Group # _____	Group # _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's Date of Birth _____	Subscriber's Date of Birth _____

Date: _____

Name of Person Completing Form: _____

Relationship to Child: _____

PATIENT INFORMATION

Child's Name:

Date of Birth:

Sex: ☐ Male ☐ Female

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Native American ☐ Other

Child's Address: _____ City: _____ State: _____ Zip: _____

County: _____ Country: _____

Primary Language(s) Spoken at Home: ☐ English ☐ Spanish ☐ Other: _____

Biological Mother Name:

Date of Birth:

Legal Guardian: ☐ Y ☐ N

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Native American ☐ Other

Phone:

Email:

Occupation:

Is the address the same as the child's? ☐ Y ☐ N

If NO, what is the address?

Biological Father Name:

Date of Birth:

Legal Guardian: ☐ Y ☐ N

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Native American ☐ Other

Phone:

Email:

Occupation:

Is the address the same as the child's? ☐ Y ☐ N

If NO, what is the address?

Institute for Child Development (ICD) Parent Questionnaire (PQ) - Ages 0-4

Step/Adoptive/Foster Mother Name: _____ Date of Birth: _____ Legal Guardian: ☐Y ☐N
Ethnicity: ☐White ☐Black ☐Asian ☐Hispanic/Latino ☐Native American ☐Other
Phone: _____
Email: _____ Occupation: _____
Is the address the same as the child's? ☐Y ☐N
If NO, what is the address? _____

Step/Adoptive/Foster Father Name: _____ Date of Birth: _____ Legal Guardian: ☐Y ☐N
Ethnicity: ☐White ☐Black ☐Asian ☐Hispanic/Latino ☐Native American ☐Other
Phone: _____
Email: _____ Occupation: _____
Is the address the same as the child's? ☐Y ☐N
If NO, what is the address? _____

If you are the legal guardian of the patient, please send a copy of the relevant guardianship documents. In cases of separation or divorce, court documents detailing custody agreements and medical decision-making authority must also be provided.

Name of Primary Care Provider: _____
Address: _____ City: _____ State: _____ Zip: _____ County: _____
Country: _____
Phone: _____ Fax: _____ Email: _____

PRESENTING CONCERNS

Please describe your main concerns about your child's development and/or behavior (e.g., speech/language development, social development; motor skills, etc.).

When did you first begin to have concerns? _____

What are your child's special qualities and strengths?

Does your child have any previous diagnoses? ☐ Y ☐ N Please describe, and if yes, email

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

us a copy of the previous diagnosis:

Do you have any other concerns about your child? Check all that apply:

- ☐ General Development
- ☐ Concerns for Autism Spectrum Disorder (ASD)
- ☐ Speech and Language Skills:
 - ☐ No words
 - ☐ Single words
 - ☐ Phrase speech, like, "Go bye, mommy juice".
 - ☐ Sentences, like "I want a cookie".
 - ☐ Conversational (2-3 turns taking when speaking with others)
- ☐ Social Skills
- ☐ Motor Skills and Coordination
 - ☐ Using utensils
 - ☐ Drawing
 - ☐ Walking, climbing, jumping
 - ☐ Falling/clumsy
 - ☐ Toe walking
- ☐ Daily Living Skills
 - ☐ Feeding/Eating
 - ☐ Sleeping
 - ☐ Self-Care/Toilet Training
- ☐ Learning Skills/Cognitive
 - ☐ Early learning (e.g., learning colors, shapes, numbers, letters, etc.)
 - ☐ Participation in group activities like daycare or preschool programs
- ☐ Sensory Sensitivities/Interests
 - ☐ Sounds: covers ears/puts fingers in ears/difficulties with loud noises such as vacuum or blender; enjoying making or hearing certain sounds
 - ☐ Lights/Movements: fascinated by things that move or spin, reflection, mirrors
 - ☐ Textures: sensitivity to clothing, food, water, putting nonedibles in mouth
 - ☐ Sensory interests: opening and closing doors; interest in touching items; smelling items

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

- ☐ Behavior
 - ☐ Hyperactivity
 - ☐ Inattention/easily distracted
 - ☐ Tantrums
 - ☐ Aggression/defiance
 - ☐ Self-harm

Can you tell us more about any of the above concerns?

What is your goal for this evaluation?

- ☐ Diagnosis
- ☐ Medication treatment
- ☐ Recommendations
- ☐ Family, pediatrician, or other clinical provider (e.g. therapist or teacher) concerns about autism spectrum disorder
- ☐ Other:

DEVELOPMENTAL HISTORY

Does your child bring things to you to show them to you? ☐ Y ☐ N ☐ Sometimes

Is your child interested in playing with other children? ☐ Y ☐ N ☐ Sometimes

When you say a word or wave your hand, does your child try to copy it? ☐ Y ☐ N ☐ Sometimes

Does your child look at you when you call his/her name? ☐ Y ☐ N ☐ Sometimes

Does your child look if you point to something across the room? ☐ Y ☐ N ☐ Sometimes

When your child plays with toys does he/she look at you to see if you are watching? ☐ Y ☐ N ☐ Sometimes

Does your child show interest in playing with a variety of objects? ☐ Y ☐ N ☐ Sometimes

How does your child usually show you something he/she wants?

- ☐ Say a word for what he/she wants
- ☐ Points with one finger
- ☐ Reaches for it
- ☐ Pulls you over or puts your hand on it

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

☐ Grunts/cries/screams

What are your child's favorite play activities?

☐ Play pretend with dolls/stuffed animals (e.g., feeding, putting doll to sleep)

☐ Reading books with you

☐ Climbing/running/being active

☐ Lining up toys/other things

☐ Watching things going around and around, like fans/wheel

☐ Other:

INTERVENTIONS AND EDUCATIONAL HISTORY

Has your child ever received Early Intervention Services? ☐ Y ☐ N *If yes, please describe the type of services and approximate date of intervention:*

Does your child receive any additional services? ☐ Y ☐ N , *if yes, please select which services your child receives outside of school or Early Intervention.*

☐ Speech Therapy

☐ Occupational Therapy

☐ Physical Therapy

☐ Play Therapy

☐ Applied Behavioral Analysis (ABA) therapy

Other:

If your child is in preschool, please respond to the following. If not, please skip to the next section:

Name of the school district:

Name of school:

Has your child ever repeated a grade? ☐ Y ☐ N

Has your child ever been evaluated by the Child Study Team? ☐ Y ☐ N

Does your child have an Individualized Education Plan (IEP)? ☐ Y ☐ N

Is your child currently receiving the following services in school?

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

- ☐ Special education
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Counseling
- ☐ Academic support
- ☐ Applied Behavioral Analysis (ABA) therapy

Other comments about school: _____

CHILD MEDICAL INFORMATION

Name of Birth Facility:

The child was delivered: ☐ Vaginal ☐ C Section

The child was born: ☐ Full term ☐ Premature: ____ weeks

Birth weight: ____ lbs ____ ozs

Any illnesses or complications during pregnancy? ☐ Y ☐ N Please describe:

Are any medications taken while pregnant? ☐ Y ☐ N Please describe:

Did the birth mother use cigarettes, alcohol, or drugs during pregnancy? ☐ Y ☐ N Please describe:

Are the biological parents cousins or related in any way? ☐ Y ☐ N Please describe:

Were there any problems during the newborn period? ☐ Y ☐ N Please describe:

Was your child born with any birth defects? ☐ Y ☐ N Please describe:

MEDICAL HISTORY

Does your child have any chronic medical diagnoses (i.e. Diabetes, Asthma, etc.): ☐ Y ☐ N
Please describe:

Is your child taking any prescribed medications? ☐ Y ☐ N Please describe:

Has your child had any past hospitalizations? ☐ Y ☐ N Please describe:

Has your child had any surgeries/procedures? ☐ Y ☐ N Please describe:

Does your child have any allergies (e.g. food, medications, environmental)? ☐ Y ☐ N
Please describe:

Does your child see any other medical specialists? ☐ Y ☐ N Please describe:

Do you have any of the following medical concerns for your child? Please check all that apply:

- ☐ Vision Problem
- ☐ Hearing Problem

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

- ☐ Frequent ear infections
- ☐ Weight/growth concerns
- ☐ Constipation/diarrhea
- ☐ Headaches/stomach aches
- ☐ Sleeping issues
- ☐ Snoring
- ☐ Asthma
- ☐ Heart problem/heart murmur
- ☐ Seizures/convulsions
- ☐ Lead poisoning
- ☐ Birthmarks
- ☐ Other, please describe:

FAMILY AND SOCIAL HISTORY

Who does the child live with? Please include names and dates of birth for each:

- ☐ Parent(s)/Guardian(s): _____
- ☐ Siblings: _____
- ☐ Other:

Is there a sibling or other close family member with a diagnosis of Autism Spectrum Disorder (ASD)?

☐ Y ☐ N If yes, please describe:

Please describe any medical, developmental, or behavioral problems in the family (including ADHD, autism spectrum disorder, behavior problems, developmental delays, learning issues, seizures/epilepsy, hearing or vision problems, anxiety, depression, etc.):

Mother: ☐ Y ☐ N If yes, please describe:
Father: ☐ Y ☐ N If yes, please describe:
Siblings: ☐ Y ☐ N If yes, please describe:
Grandparents: ☐ Y ☐ N If yes, please describe:
Cousins: ☐ Y ☐ N If yes, please describe:
Aunts/Uncles: ☐ Y ☐ N If yes, please describe:

Are there any stressors or history of trauma that may have impacted your child and/or family? (i.e. separation, divorce, illness)

☐ Y ☐ N If yes, please describe:

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 0-4

Please indicate if there is anything else that may assist us in better understanding your child:

In the event of visit availability due to last-minute cancellations, if age-specific forms, IEPs, and/or Child Study Evaluations have been received, would you like to be contacted? ☐Y ☐N



Complete the POSI on the next page if
your child is 18 months to 34 months, 31
days of age.



POSI:

18 months, 0 days to 34 months, 31 days
V1.07, 4/1/17

Child's Name:

Birth Date:

Today's Date:

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)

Does your child bring things to you to show them to you?	Many times a day ☐	A few times a day ☐	A few times a week ☐	Less than once a week ☐	Never ☐
Is your child interested in playing with other children?	Always ☐	Usually ☐	Sometimes ☐	Rarely ☐	Never ☐
When you say a word or wave your hand, will your child try to copy you?	☐	☐	☐	☐	☐
Does your child look at you when you call his or her name?	☐	☐	☐	☐	☐
Does your child look if you point to something across the room?	☐	☐	☐	☐	☐
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
(please check all that apply)	☐	☐	☐	☐	☐
What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
(please check all that apply)	☐	☐	☐	☐	☐

For acknowledgments, validation, and other information concerning the POSI, please see www.theswyc.org/posi



Complete the CSBS on the next page if
your child is 6 months to 24 months of age.



CSBS DP Infant-Toddler Checklist

Child's name: _____ Date of birth: _____ Date filled out: _____

Was birth premature? _____ If yes, how many weeks premature? _____

Filled out by: _____ Relationship to child: _____

Instructions for caregivers: This Checklist is designed to identify different aspects of development in infants and toddlers. Many behaviors that develop before children talk may indicate whether or not a child will have difficulty learning to talk. This Checklist should be completed by a caregiver when the child is between **6 and 24 months of age** to determine whether a referral for an evaluation is needed. The caregiver may be either a parent or another person who nurtures the child daily. Please check all the choices that best describe your child's behavior. If you are not sure, please choose the closest response based on your experience. **Children at your child's age are not necessarily expected to use all the behaviors listed.**

Emotion and Eye Gaze

- | | | | |
|---|----------------------------------|------------------------------------|--------------------------------|
| 1. Do you know when your child is happy and when your child is upset? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 2. When your child plays with toys, does he/she look at you to see if you are watching? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 3. Does your child smile or laugh while looking at you? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 4. When you look at and point to a toy across the room, does your child look at it? | ☐ Not Yet | ☐ Sometimes | ☐ Often |

Communication

- | | | | |
|--|----------------------------------|------------------------------------|--------------------------------|
| 5. Does your child let you know that he/she needs help or wants an object out of reach? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 6. When you are not paying attention to your child, does he/she try to get your attention? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 7. Does your child do things just to get you to laugh? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 8. Does your child try to get you to notice interesting objects—just to get you to look at the objects, not to get you to do anything with them? | ☐ Not Yet | ☐ Sometimes | ☐ Often |

Gestures

- | | | | |
|--|----------------------------------|------------------------------------|--------------------------------|
| 9. Does your child pick up objects and give them to you? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 10. Does your child show objects to you without giving you the object? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 11. Does your child wave to greet people? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 12. Does your child point to objects? | ☐ Not Yet | ☐ Sometimes | ☐ Often |
| 13. Does your child nod his/her head to indicate yes? | ☐ Not Yet | ☐ Sometimes | ☐ Often |

Sounds

- | | | | | | |
|---|----------------------------------|------------------------------------|--------------------------------|------------------------------|---------------------------------|
| 14. Does your child use sounds or words to get attention or help? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |
| 15. Does your child string sounds together, such as <i>uh oh, mama, gaga, bye bye, bada</i> ? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |
| 16. About how many of the following consonant sounds does your child use:
<i>ma, na, ba, da, ga, wa, la, ya, sa, sha</i> ? | ☐ None | ☐ 1–2 | ☐ 3–4 | ☐ 5–8 | ☐ over 8 |

Words

- | | | | | | |
|--|----------------------------------|------------------------------------|--------------------------------|--------------------------------|----------------------------------|
| 17. About how many different words does your child use meaningfully that you recognize (such as <i>baba</i> for bottle; <i>gaggie</i> for doggie)? | ☐ None | ☐ 1–3 | ☐ 4–10 | ☐ 11–30 | ☐ over 30 |
| 18. Does your child put two words together (for example, <i>more cookie, bye bye Daddy</i>)? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |

Understanding

- | | | | | | |
|---|----------------------------------|------------------------------------|--------------------------------|--------------------------------|----------------------------------|
| 19. When you call your child's name, does he/she respond by looking or turning toward you? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |
| 20. About how many different words or phrases does your child understand without gestures? For example, if you say "where's your tummy," "where's Daddy," "give me the ball," or "come here," without showing or pointing, your child will respond appropriately. | ☐ None | ☐ 1–3 | ☐ 4–10 | ☐ 11–30 | ☐ over 30 |

Object Use

- | | | | | | |
|---|---|------------------------------------|-------------------------------------|------------------------------------|---------------------------------|
| 21. Does your child show interest in playing with a variety of objects? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |
| 22. About how many of the following objects does your child use appropriately:
cup, bottle, bowl, spoon, comb or brush, toothbrush, washcloth, ball, toy vehicle, toy telephone? | ☐ None | ☐ 1–2 | ☐ 3–4 | ☐ 5–8 | ☐ over 8 |
| 23. About how many blocks (or rings) does your child stack? | Stacks ☐ None | ☐ 2 blocks | ☐ 3–4 blocks | ☐ 5 or more | |
| 24. Does your child pretend to play with toys (for example, feed a stuffed animal, put a doll to sleep, put an animal figure in a vehicle)? | ☐ Not Yet | ☐ Sometimes | ☐ Often | | |

Do you have any concerns about your child's development? ☐ yes ☐ no If yes, please describe on back.



Complete the ADHD Rating Scale on the next page if your child is 3 years to 5 years of age.

ADHD Rating Scale IV - Preschool Version

Child's Name: _____ Sex: M F Age: _____

Completed By: _____ Relationship: _____

Circle the number that <u>best describes</u> the child's behavior over the past 6 months.		Rarely or never	Sometimes	Often	Very often
1.	Fails to give close attention to details (i.e. rushes through activities, makes careless mistakes)	0	1	2	3
2.	Fidgets with hands or feet or squirms in seat (taps hands or feet)	0	1	2	3
3.	Has difficulty sustaining attention in tasks or play activities	0	1	2	3
4.	Leaves seat in classroom, during meals, or in other situations in which remaining seated is expected	0	1	2	3
5.	Does not seem to listen when spoken to directly (tunes you out)	0	1	2	3
6.	Runs about or climbs excessively in situations in which it is inappropriate	0	1	2	3
7.	Does not follow through on instructions or fails to finish tasks (i.e. "go upstairs, get your shoes and socks"; has difficulty with transitions)	0	1	2	3
8.	Has difficulty playing quietly (alone or in groups)	0	1	2	3
9.	Has difficulty organizing tasks and activities (i.e. choosing an activity, getting materials, doing steps in order)	0	1	2	3
10.	Is "on the go" or acts as if "driven by a motor"	0	1	2	3
11.	Avoids tasks that require sustained mental effort (i.e. puzzles, learning ABC's, writing name)	0	1	2	3
12.	Talks excessively	0	1	2	3
13.	Loses things necessary for tasks or activities (i.e. mittens, shoes, backpack)	0	1	2	3
14.	Blurts out answers before questions have been completed	0	1	2	3
15.	Is easily distracted	0	1	2	3
16.	Has difficulty awaiting turn	0	1	2	3
17.	Is forgetful in daily activities (i.e. forgets papers, forgets directions)	0	1	2	3
18.	Interrupts or intrudes on others	0	1	2	3

Adapted and reprinted with permission from Guilford Press.

“AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION” FORM INSTRUCTIONS

To ensure the secure and accurate handling of your child's protected health information, please follow these instructions.

Completing the Form:

- **Recipient of Information:** In the section titled "I authorize Hackensack Meridian Health to release information to," please specify who will receive the medical records.
 - If you do not plan to send the records to an external party (such as a school, insurance company, or law firm), please enter the parent or guardian's full name and contact information in this section.
- **Highlighted Sections:** Please complete all highlighted areas by checking the boxes that apply:
 - **Location of Services:** Select “Hackensack University Medical Center”
 - **Information to be Released:** For a complete copy of your child's records, select “Other” and write “All Medical Records”
 - **Purpose of Release:**
 - Caregiver only? Select “Personal Use”
 - Records being sent out? Select “Other”
 - **Requested Format:** Select all that apply
- **Patient Age Consideration:** The sections “*Release Requiring Specific Consent*” & “*Consent of Minor*” should only be completed if the patient is 13 years of age or older.
- **Signature:** The parent or legal guardian must sign and date the second page of the form.



Hackensack
Meridian Health



R10000

PATIENT LABEL

**AUTHORIZATION TO USE OR
DISCLOSE PROTECTED HEALTH
INFORMATION**

CMR-003 (12-20-23) PAGE 1 OF 2

Patient Name	Date of Birth	Medical Record #	Contact Number
Address (Street, City, State, Zip Code)			

I authorize Hackensack Meridian Health to release information to:

Organization/Recipient:	Attn:
Address (Street, City, State, Zip Code)	
Phone #:	Fax #:

Location of Services:

☐ Jersey Shore University Medical Center	☐ Hackensack University Medical Center	☐ Carrier Clinic	☐ Bayshore Medical Center
☐ JFK University Medical Center	☐ Southern Ocean Medical Center	☐ Raritan Bay Medical Center	☐ Palisades Medical Center
☐ Riverview Medical Center	☐ Ocean University Medical Center	☐ Old Bridge Medical Center	☐ Carrier Clinic
☐ Other (specify):			

Information to Be Released:

Requesting records (date range): from:		to:	
☐ Clinic Notes	☐ Therapy Service Reports	☐ Operative/Procedure Notes	☐ Lab/Pathology Reports
☐ Discharge Summaries	☐ Emergency Dept Records	☐ Radiology Images	☐ Radiology ☐ Reports
☐ Drug/Alcohol Records	☐ Abstract	☐ Other (specify):	

Purpose of Release:

☐ Continuing Care	☐ Personal use	☐ Transfer to another provider	☐ Legal	☐ Other (specify):
--	---------------------------------------	---	--------------------------------	---

Release Requiring Specific Consent:

I specifically authorize HMH to release health information checked below:				
☐ Reproductive Health Care	☐ Sexually Transmitted Diseases	☐ HIV/AIDS	☐ Mental Health	☐ Alcohol/Drug Abuse*

CONSENT OF MINOR [DO NOT COMPLETE IF YOUR CHILD IS NOT 13 YRS OR OLDER]

A minor patient's signature is required in order to release the following Information: 1) conditions relating to reproductive health care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 13 and older), 2) drug and alcohol abuse diagnosis or treatment, (age 13 and older), and 3) mental health conditions, psychotherapy (age 13 and older).

By signing this form, I certify that I am the individual to the patient whose protected health information as noted above is being requested for release:

Signature of Patient/Minor	Print Name	Date Signed
----------------------------	------------	-------------

Requested Format:

☐ Paper	☐ Electronic Copy (encrypted USB, CD)	☐ Fax No:	☐ Secured email:
--------------------------------	--	----------------------------------	---

EHI Export - is a machine-readable format of your medical records which can be uploaded to another Electric Health Record (EHR). If you would like to request a copy of your records in a machine-readable format, please indicate by adding your initials here_____.



**AUTHORIZATION TO USE OR
DISCLOSE PROTECTED HEALTH
INFORMATION**

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by informing in writing the HMH Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further releases or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below, unless another date or event is entered here _____.

By signing this form, I certify that I am the individual or legally authorized representative to the patient whose protected health information as noted above is being requested for release.

Signature of Patient or Legal Representative

Date Signed

Print Name

Relationship to Patient

Additional Information

FEE FOR COPYING MEDICAL RECORDS - There may be a fee for copying the medical records. Please ask the Health Information Management personnel for information about the fee schedule.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION - *Drug and Alcohol Abuse and Treatment Records are protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR QUESTIONS, CONTACT RESPECTIVE SITE HEALTH INFORMATION MANAGEMENT

Hackensack Meridian Health Hospital Campus Health Information Department			
Campus	Address	Phone #	Fax#
Bayshore Medical Center	727 North Beers St. Holmdel, NJ 07730	732-739-5933 or 732-739-5985	732-888-7332
Carrier Clinic	252 Co Rd 601 Belle Mead, NJ 08502	908-281-1479	908-281-1671
Hackensack University Medical Center	30 Prospect Ave. Hackensack, NJ 07601	551-996-2074	551-996-2347
Jersey Shore University Medical Center	1945 HWY 33 Neptune, NJ 07753	732-776-4771	732-776-4692
JFK University Medical Center	65 James Street Edison, NJ 08820	732-321-7000 ext.62631 or 732-321-7177	732-549-8569
Ocean University Medical Center	425 Jack Martin Blvd. Brick, NJ 08724	732-840-3331	732-836-4269 or 732-840-9616
Palisades Medical Center	7600 River Road North Bergen, NJ 07047	201-854-5081 or 201-854-5083	201-854-8360 or 201-854-8546
Raritan Bay Medical Center	530 New Brunswick Ave. Perth Amboy, NJ 08861	732 324 5391	732-324-4883
Old Bridge Medical Center	3 Hospital Plaza Old Bridge, NJ 08857	732 360-4237	732-360-4134
Riverview Medical Center	1 Riverview Plaza Red Bank, NJ 07701	732-530-2510	732-224-7210
Southern Ocean Medical Center	1140 Route 72 West Manahawkin, NJ 08050	609-978 3820	609-978-8965

HACKENSACK MERIDIAN HEALTH
DAX Copilot
AI Audio Recording Consent Form

Healthcare clinicians today spend a significant amount of time on computers documenting care, which takes away from their ability to spend time focused on patients. To support our mission of providing high quality care, Hackensack Meridian Health is piloting the use of a new technology which uses artificial intelligence and associated workflows to generate documentation based on recorded audio of patient visits. This technology is expected to significantly reduce the amount of time your clinician spends on documentation and allow more time for providing care to you and other patients. Hackensack Meridian Health uses Nuance Dragon Ambient eXperience (“DAX Copilot”), which is a third-party tool to process the recorded audio. All documentation will be reviewed, corrected, and approved by your clinician to ensure the accuracy and completeness of your medical record.

Please sign below to indicate your consent to having your visit audio recorded and processed for the purpose of documenting your care. The recording and associated documentation may also be used for the further improvement of DAX Copilot, as further described in the HIPAA authorization, which is simultaneously being provided to you. Your consent is voluntary. However, you must sign both the HIPAA authorization and this consent before Hackensack Meridian Health may employ DAX Copilot for your visit(s).

This consent is voluntary, and your care will not be conditioned on providing consent.

I hereby consent to the recording of my visit today as well as any future visits. I understand that I may revoke consent to the recording of future visits at any time by contacting Cynthia Coronel-Becker, Director of Privacy at privacy@HMHN.org.

Signature of Patient or Personal Representative

Date

If signed by other than patient: PRINT Representative Name

Phone Number

If signed by other than patient: State relationship to patient



The Institute for Child Development
Developmental Pediatrics
Phone: 551-996-5555
Fax: 551-996-5034

REQUEST FOR PEDIATRIC SPECIALIST CONSULTATION

For patients scheduled for a Developmental Pediatric Evaluation, this form must be completed by the patient's pediatrician or referring physician. Please return the completed form by fax to (551) 996-5034 or email to instituteforchilddev@hmn.org.

Note: This form is *in addition to* any referral required by your insurance company.

Patient Name: _____ Patient Date of Birth: _____

Reason for Consultation (check all that apply & add additional concerns/information):

- ☐ Concerns for autism spectrum disorder (ASD)
- ☐ Developmental concerns
- ☐ Hyperactivity / fidgeting behavior
- ☐ Inattention / distractability
- ☐ Speech / language skills
- ☐ Motor skills / coordination
- ☐ Learning difficulties / cognitive
- ☐ Daily living skills
- ☐ Sensory sensitivities / interests
- ☐ Challenging behavior
- ☐ Other:

Physician Requesting Consultation: _____

NPI #: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

Physician's Signature

Date

INSURANCE & BILLING INFORMATION

To understand your insurance coverage for an evaluation at the Institute for Child Development (part of Hackensack University Medical Center), please contact your insurance carrier. When you call, refer to the procedure codes listed below and mention that we bill as an outpatient facility under Hackensack University Medical Center (NPI: 1457456279), not individual providers.

Important: Many insurers require a referral or pre-authorization from your child's pediatrician. Without the required referral at the time of the evaluation, we cannot bill your insurance. If you do not have a referral, you can reschedule your appointment (551-996-5555) or pay for the evaluation yourself.

We will contact your insurance company before your appointment to verify coverage and any limitations. You will receive a call informing you of any payment due at the time of service.

Procedure Codes:

- Developmental Pediatric Study: 99245
- Office Visit (Follow-Up): 99213, 99214, 99215, 99417
- Developmental Testing: 96112, 96113
- Developmental Screening: 96116
- Medication Visits (Follow-up): 99213, 99214, 99215, 99417
- Prolonged Services: 99354, 99417
- Dysphagia (Eating and Swallowing): 92610
- Modified Barium Swallow Study:
 - Speech Pathologist Portion: 92611
 - Radiologist Portion: 74230
- Speech/Language Evaluation: 92523
- Stuttering Evaluation: 92521
- Voice and Resonance Evaluation: 92524
- Evaluation of Speech Sound Production/Articulation: 92522
- Occupational Therapy Evaluation: 97003
- Occupational Therapy Re-evaluation: 97004
- Physical Therapy Evaluation: 97001
- Physical Therapy Re-evaluation: 97002