

Institute for Child Development (ICD)
Parent Questionnaire (PQ) - Ages 5+

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:

1. Complete the Parent Questionnaire, ADHD Toolkit Parent-Informant Form, and SCARED - Parent Version.
2. Sign the Authorization to Use or Disclose Protected Health Information form.
3. Email us copies of prior Child Study Team Evaluations (if applicable).
4. Email us copies of Individualized Education Plans (IEP) (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 S.I.F.T.E.R, ADHD Toolkit Teacher-Informant Form, and Teacher Remarks.

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.

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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? _____

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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., language development, learning, social skills, behavior, 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 us a copy of the previous evaluations:

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

- ☐ General Development
- ☐ Speech and Language Skills
- ☐ Social Skills (e.g. developing friendships; interacting with others)
- ☐ Motor Skills and Coordination
- ☐ Daily Living Skills
 - ☐ Feeding/Eating
 - ☐ Sleeping
 - ☐ Bathing
 - ☐ Self-Care
- ☐ Learning Skills/Cognitive Development
- ☐ Sensory Sensitivities/Interests
- ☐ Behavior/Emotions
 - ☐ Hyperactivity
 - ☐ Inattention
 - ☐ Tantrums
 - ☐ Anxiety
 - ☐ Depressed mood
 - ☐ 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
- ☐ Other:

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INTERVENTIONS AND EDUCATIONAL HISTORY

Did your child receive Early Intervention Services? ☐ Y ☐ N If yes, please describe the type of services and for how long:

Name of the school district:

Name of school:

Grade:

Name of current teacher:

Current teacher email address:

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 a Section 504 Plan? ☐ Y ☐ N

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

Is your child currently receiving the following services in school?

- ☐ Special education services
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Counseling
- ☐ Applied Behavioral Analysis (ABA) therapy
- ☐ Other:

Does your child receive any additional services outside of school? ☐ Y ☐ N

- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Counseling/Therapy
- ☐ Applied Behavioral Analysis (ABA) therapy
- ☐ Perform Care services
- ☐ Other:

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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 (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
- ☐ Frequent ear infections
- ☐ Weight/growth concerns
- ☐ Constipation/diarrhea
- ☐ Headaches/stomach aches
- ☐ Sleeping issues
- ☐ Snoring
- ☐ Asthma
- ☐ Heart problem/heart murmur
- ☐ Seizures/convulsions

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- ☐ 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 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 trauma that may have impacted your child and/or family? (i.e. separation, divorce, illness)

- ☐ Y ☐ N If yes, please describe:

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

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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

CLINICIAN TOOLS



ADHD



Vanderbilt Assessment Scale: ADHD Toolkit Parent-Informant Form

Child's name: _____ Parent's name: _____

Date: _____ DOB: _____ Age: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

 This evaluation is based on a time when your child: ☐ Was on medication ☐ Was not on medication ☐ Not sure

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
1. Does not pay attention to details or makes mistakes that seem careless with, for example, homework	☐	☐	☐	☐
2. Has difficulty keeping attention on what needs to be done	☐	☐	☐	☐
3. Does not seem to listen when spoken to directly	☐	☐	☐	☐
4. Does not follow through on instructions and does not finish activities (not because of refusal or lack of comprehension)	☐	☐	☐	☐
5. Has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	☐	☐	☐	☐
7. Loses things necessary for tasks or activities (eg, toys, assignments, pencils, books)	☐	☐	☐	☐
8. Is easily distracted by noises or other stimuli	☐	☐	☐	☐
9. Is forgetful in daily activities	☐	☐	☐	☐

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 2s & 3s 0 / 9

10. Fidgets with or taps hands or feet or squirms in seat	☐	☐	☐	☐
11. Leaves seat when remaining seated is expected	☐	☐	☐	☐
12. Runs about or climbs too much when remaining seated is expected	☐	☐	☐	☐
13. Has difficulty playing or beginning quiet play games	☐	☐	☐	☐
14. Is on the go or often acts as if "driven by a motor"	☐	☐	☐	☐
15. Talks too much	☐	☐	☐	☐
16. Blurts out answers before questions have been completed	☐	☐	☐	☐
17. Has difficulty waiting his or her turn	☐	☐	☐	☐
18. Interrupts or intrudes into others' conversations or activities or both	☐	☐	☐	☐

For Office Use Only
 2s & 3s 0 / 9

Vanderbilt Assessment Scale: ADHD Toolkit Parent-Informant Form



Child's name: _____ Today's date: _____

Behavior	Never (0)	Occasionally (1)	Often (2)	Very Often (3)
19. Loses temper	☐	☐	☐	☐
20. Is touchy or easily annoyed	☐	☐	☐	☐
21. Is angry or resentful	☐	☐	☐	☐
22. Argues with authority figures or adults	☐	☐	☐	☐
23. Actively defies or refuses to adhere to requests or rules	☐	☐	☐	☐
24. Deliberately annoys people	☐	☐	☐	☐
25. Blames others for his or her mistakes or misbehaviors	☐	☐	☐	☐
26. Is spiteful and wants to get even	☐	☐	☐	☐
For Office Use Only 2s & 3s <u>0</u> / 8				
27. Bullies, threatens, or intimidates others	☐	☐	☐	☐
28. Starts physical fights	☐	☐	☐	☐
29. Has used a weapon that can cause serious harm (eg, bat, knife, brick, gun)	☐	☐	☐	☐
30. Has been physically cruel to people	☐	☐	☐	☐
31. Has been physically cruel to animals	☐	☐	☐	☐
32. Has stolen while confronting the person	☐	☐	☐	☐
33. Has forced someone into sexual activity	☐	☐	☐	☐
34. Has deliberately set fires to cause damage	☐	☐	☐	☐
35. Deliberately destroys others' property	☐	☐	☐	☐
36. Has broken into someone else's home, business, or car	☐	☐	☐	☐
37. Lies to get out of trouble, to obtain goods or favors, or to avoid obligations (ie, cons others)	☐	☐	☐	☐
38. Has stolen items of value	☐	☐	☐	☐
39. Has stayed out at night without permission beginning before age 13	☐	☐	☐	☐
40. Has run away from home twice or once for an extended period	☐	☐	☐	☐
41. Is often truant from school (skips school)	☐	☐	☐	☐
For Office Use Only 2s & 3s <u>0</u> / 15				
42. Is fearful, anxious, or worried	☐	☐	☐	☐
43. Is afraid to try new things for fear of making mistakes	☐	☐	☐	☐
44. Feels worthless or inferior	☐	☐	☐	☐
45. Blames self for problems or feels guilty	☐	☐	☐	☐
46. Feels lonely, unwanted, or unloved; often says that no one loves him or her	☐	☐	☐	☐
47. Is sad, unhappy, or depressed	☐	☐	☐	☐
48. Is self-conscious or easily embarrassed	☐	☐	☐	☐
For Office Use Only 2s & 3s <u>0</u> / 7				

Vanderbilt Assessment Scale: ADHD Toolkit Parent-Informant Form



Child's name: _____ Today's date: _____

Academic and Social Performance	Excellent (1)	Above Average (2)	Average (3)	Somewhat of a Problem (4)	Problematic (5)
49. Overall school performance	☐	☐	☐	☐	☐
50. Reading	☐	☐	☐	☐	☐
51. Writing	☐	☐	☐	☐	☐
52. Mathematics	☐	☐	☐	☐	☐
53. Relationship with parents	☐	☐	☐	☐	☐
54. Relationship with siblings	☐	☐	☐	☐	☐
55. Relationship with peers	☐	☐	☐	☐	☐
56. Participation in organized activities (eg, teams)	☐	☐	☐	☐	☐

For Office Use Only
 4s 0 / 8

For Office Use Only
 5s 0 / 8

How old was your child when you first noticed the behaviors?

Tic behaviors: To the best of your knowledge, please indicate if your child displays the following behaviors:

1. Motor tics: Rapid, repetitive movements such as eye blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, and rapid kicks.

- ☐ No tics present.
- ☐ Yes, they occur nearly every day but go unnoticed by most people.
- ☐ Yes, noticeable tics occur nearly every day.

2. Phonic (vocal) tics: Repetitive noises including, but not limited to, throat clearing, coughing, whistling, sniffing, snorting, screeching, barking, grunting, and repetition of words or short phrases.

- ☐ No tics present.
- ☐ Yes, they occur nearly every day but go unnoticed by most people.
- ☐ Yes, noticeable tics occur nearly every day.

3. If YES to 1 or 2, do these tics interfere with your child's activities (eg, reading, writing, walking, talking, eating)?

- ☐ No ☐ Yes

Vanderbilt Assessment Scale: *ADHD Toolkit* Parent-Informant Form



Child's name: _____ Today's date: _____

Previous diagnosis and treatment: Please answer the following questions to the best of your knowledge:

1. Has your child been diagnosed as having ADHD or ADD?
☐ No ☐ Yes
2. Is he or she on medication for ADHD or ADD?
☐ No ☐ Yes
3. Has your child been diagnosed as having a tic disorder or Tourette syndrome?
☐ No ☐ Yes
4. Is he or she on medication for a tic disorder or Tourette disorder?
☐ No ☐ Yes

Adapted from the Vanderbilt rating scales developed by Mark L. Wolraich, MD.

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Total number of questions scored 2 or 3 in questions 1–9: _____ 0

Total number of questions scored 2 or 3 in questions 10–18: _____ 0

Total number of questions scored 2 or 3 in questions 19–26: _____ 0

Total number of questions scored 2 or 3 in questions 27–41: _____ 0

Total number of questions scored 2 or 3 in questions 42–48: _____ 0

Total number of questions scored 4 in questions 49–56: _____ 0

Total number of questions scored 5 in questions 49–56: _____ 0

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CLINICIAN TOOLS



Screen for Child Anxiety Related Disorders (SCARED)—Parent Version

Parent's name _____ Date _____

Child's name _____

PARENT Version—Pages 1 and 2 (to be filled out by the PARENT)

Directions: Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then, for each statement, check the box that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe.	☐	☐	☐	PA/SO
2. My child gets headaches when he/she is at school.	☐	☐	☐	SCH
3. My child doesn't like to be with people he/she doesn't know well.	☐	☐	☐	SOC
4. My child gets scared if he/she sleeps away from home.	☐	☐	☐	SEP
5. My child worries about other people liking him/her.	☐	☐	☐	GA
6. When my child gets frightened, he/she feels like passing out.	☐	☐	☐	PA/SO
7. My child is nervous.	☐	☐	☐	GA
8. My child follows me wherever I go.	☐	☐	☐	SEP
9. People tell me that my child looks nervous.	☐	☐	☐	PA/SO
10. My child feels nervous with people he/she doesn't know well.	☐	☐	☐	SOC
11. My child gets stomachaches at school.	☐	☐	☐	SCH
12. When my child gets frightened, he/she feels like he/she is going crazy.	☐	☐	☐	PA/SO
13. My child worries about sleeping alone.	☐	☐	☐	SEP
14. My child worries about being as good as other kids.	☐	☐	☐	GA
15. When my child gets frightened, he/she feels like things are not real.	☐	☐	☐	PA/SO
16. My child has nightmares about something bad happening to his/her parents.	☐	☐	☐	SEP
17. My child worries about going to school.	☐	☐	☐	SCH
18. When my child gets frightened, his/her heart beats fast.	☐	☐	☐	PA/SO

Screen for Child Anxiety Related Disorders (SCARED)—Parent Version



Parent's name _____ Date _____

Child's name _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
19. He/she gets shaky.	☐	☐	☐	PA/SO
20. My child has nightmares about something bad happening to him/her.	☐	☐	☐	SEP
21. My child worries about things working out for him/her.	☐	☐	☐	GA
22. When my child gets frightened, he/she sweats a lot.	☐	☐	☐	PA/SO
23. My child is a worrier.	☐	☐	☐	GA
24. My child gets really frightened for no reason at all.	☐	☐	☐	PA/SO
25. My child is afraid to be alone in the house.	☐	☐	☐	SEP
26. It is hard for my child to talk with people he/she doesn't know well.	☐	☐	☐	SOC
27. When my child gets frightened, he/she feels like he/she is choking.	☐	☐	☐	PA/SO
28. People tell me that my child worries too much.	☐	☐	☐	GA
29. My child doesn't like to be away from his/her family.	☐	☐	☐	SEP
30. My child is afraid of having anxiety (or panic) attacks.	☐	☐	☐	PA/SO
31. My child worries that something bad might happen to his/her parents.	☐	☐	☐	SEP
32. My child feels shy with people he/she doesn't know well.	☐	☐	☐	SOC
33. My child worries about what is going to happen in the future.	☐	☐	☐	GA
34. When my child gets frightened, he/she feels like throwing up.	☐	☐	☐	PA/SO
35. My child worries about how well he/she does things.	☐	☐	☐	GA
36. My child is scared to go to school.	☐	☐	☐	SCH
37. My child worries about things that have already happened.	☐	☐	☐	GA
38. When my child gets frightened, he/she feels dizzy.	☐	☐	☐	PA/SO
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	☐	☐	☐	SOC
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	☐	☐	☐	SOC
41. My child is shy.	☐	☐	☐	SOC



To be completed by CLINICIAN:

Child's name _____ Date _____

SCORING:

A total score of ≥ 25 may indicate the presence of an Anxiety Disorder . Scores higher than 30 are more specific.	TOTAL= 0
A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms .	PA/SO= 0
A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder .	GA= 0
A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder .	SEP= 0
A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Phobic Disorder .	SOC = 0
A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance .	SCH= 0

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10), 1230–6.

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“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):
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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
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Requested Format:

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