LSUHSC HDC ASD-ID Clinic Intake Application Packet

School of Allied Health Professions

Patient Registration/Update

◉ New Patient ○ Update

Last Name First Name Middle Name

◉ Male ○ Female

Date of Birth Social Security Number

Patient Street Address

City State Zip Phone Number

Responsible Person's Name Responsible Person's E-mail Address

Responsible Person's Street Address

City State Zip Phone Number

Responsible Person's Date of Birth Responsible Person's Social Security Number

Responsible Person's Relationship to Patient

Parent
- ◉ Biological
- ○ Adoptive
- ○ Foster

○ Guardian

○ Other (please specify) _____

Emergency Contact's Name Phone Number

Emergency Contact's Relationship to Patient

Parent
- ◉ Biological
- ○ Adoptive
- ○ Foster

○ Guardian

○ Other (please specify) _____

Primary Insurance

Insurance Company Name | Contract/Certificate # | Policy or Group #

Insurance Company Address

City | State | Zip | Phone Number

Subscriber Name | Subscriber Social Security Number

Subscriber Employer Name | Employer Phone Number

Subscriber's Relationship to Patient

- Parent
  - ○ Biological
  - ○ Adoptive
  - ○ Foster
- ○ Guardian
- ○ Other (please specify) _____

Secondary Insurance

Insurance Company Name | Contract/Certificate # | Policy or Group #

Insurance Company Address

City | State | Zip | Phone Number

Subscriber Name | Subscriber Social Security Number

Subscriber Employer Name | Employer Phone Number

Subscriber's Relationship to Patient

- Parent
  - ◉ Biological
  - ○ Adoptive
  - ○ Foster
- ○ Guardian
- ○ Other (please specify) _____

For Office Use Only

Appointment Date | Account Number

Clinician | Referring Provider

Patient Consent for Treatment

I do hereby voluntarily consent to such treatment as is deemed necessary by the clinician. I hereby release Louisiana State University Health Sciences Center and its personnel from any responsibilities resulting from illness, ill effect, or reaction from the treatment ordered by my physician.

Patient Guarantee and Authorizations

In consideration for and to cause Louisiana State University Health Sciences Center School of Allied Health Professions Clinics to treat _____ (print patient name) as a private patient, the undersigned unconditionally guarantees payment of all cost charges and expenses of the Louisiana State University Health Sciences Center School of Allied Professions Clinics to apply for benefit on my behalf for covered services rendered by LSU School of Allied Health Clinics, and request all payments be made to "LSUHSC." Furthermore, I understand and agree any unpaid balance not covered by my insurance policy will be paid directly by me.

Insurance forms are mailed to:
(Please indicate with a check.)

- ☐ Employer
- ☐ Insurance Company
- ☐ Other (please specify)

_____

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care procedures. You have the right to revoke this consent, in writing, except where we have made disclosures in reliance on your prior consent.

Patient's Signature	Date
Other Authorized Signature	Date
Relationship of Authorized Signature	Reason Patient Cannot Sign

In case of emergency, please contact:

Name and Relationship	Telephone Number

Revised 10/27/15

Acknowledgement of Receipt of Notice of Privacy Practices

I, (Patient's Name—please print), acknowledge that I have received a copy of the Notice of Privacy Practices of LSUHSC-New Orleans on this date.

Signature—Patient or Patient's Representative Date

Health Care Provider's Documentation of Good Faith Effort to Obtain Acknowledgement of Receipt

If the Acknowledgement could not be obtained prior to the date of first service to the patient, or, in an emergency situation, as soon as reasonably practicable after the emergency has resolved, describe below the efforts made to obtain the written Acknowledegement and the reasons why the written Acknowledgement could not be obtained. If the patient refused to provide the written Acknowledgement, please so state.
Efforts to obtain written Acknowledgement:

Reasons written Acknowledgement could not be obtained:

Signature of Healthcare Provider Date

Printed Name of Healthcare Provider

Revised 1/20/16

Consent to Photograph, Videotape, Audiotape

I give permission to Louisiana State University Health Sciences Center (LSUHSC) to photograph, videotape, or audiotape me and/or my child,

_____, during evaluation and treatment sessions. I understand that these may be used for teaching, professional presentations or for publication. Photographs and tapes will be the property of the department and will be held in confidence. In some instances, the name of you or your child may be used. Please indicate any restrictions below or strike out and initial any exclusions.

_____
Name

_____
Street Address

_____
City State Zip Phone Number

_____
Signature Date

Patient's Request for Access to and Obtain a Copy of Their Protected Health Information

Patient:

I, _____, request access to my protected health information contained in the medical records or billing records maintained by LSUHSC-NO to review the contents and obtain copies.

OR

Patient's Representative*

I, _____, request access to the protected health information of _____ contained in the medical records or billing records maintained by LSUHSC-NO to review the contents and obtain copies.

I have the right to inspect and request copies of whatever portions or the entirety of the health records as well as to request a summary explanation of these records and that LSUHSC-NO will arrange a convenient time and place for me to conduct a review of this protected health information. I request access and/or copies/ summaries of the following information:

From (date): _____

To (date): _____

- ☐ Complete medical record
- ☐ History & physical exam
- ☐ Photographs, video
- ☐ Other _____
- ☐ Diagnosis & treatment codes
- ☐ Consultation reports
- ☐ Complete billing record
- ☐ Discharge summary
- ☐ Progress notes
- ☐ Itemized bill

I would like this information provided to me by (check one):

- ◉ Person pick-up
- ○ U.S. Postal Service to:

_____
Street Address

_____ _____
City State Zip

_____
Signature Date

* Individual must be listed as an authorized person on the HIPAA Release of Protected Health Information form.

Authorization for Release of Public Health Information

Make two copies. Provide one to patient. Maintain original in LSUHSC-NO Files.

Last Name First Name Middle Name

Date of Birth Social Security Number

Patient Street Address

City State Zip Phone Number

Authority to Release Protected Health Information

I hereby authorize _____ to release the information identified in this authorization form from the medical records of

_____ and provide such authorization to

_____

Information to Be Released

Covering the Periods of Healthcare Care: From _____ to _____
Please check type of information to be released:

- ☐ Complete health record
- ☐ History and physical exam
- ☐ Laboratory test results
- ☐ Photographs, videotapes
- ☐ Diagnosis and treatment codes
- ☐ Consultation reports
- ☐ X-ray reports
- ☐ Complete billing record
- ☐ Discharge summary
- ☐ Progress notes
- ☐ X-ray films/images
- ☐ Itemized bill
- ☐ Psychotherapy notes *(If above is checked, any other PHI must be listed on a separate authorization form.)*

☐ Other, (specify) _____

Purpose of the Requested Disclosure of Protected Health Information

I am authorizing the release of my Protected Health Information for the following purposes (e.g., a purpose may be "at the request of the individual"):

If the authorization is for the purposes of marketing or the sale of PHI, will LSUHSC-NO receive any payment as a result of this authorization? Initial if Yes _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

☐ I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information, I agree to its release.

☐ I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, the authorization may be revoked at any time by submitting a written notice to _____ at _____. Unless revoked, this authorization will expire on the following date, or after the following time period or event _____.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services are being provided to me for the purpose of providing information to a third-party (e.g. fitness-for-work test), I understand that services may be denied if I do not authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health information to be used or disclosed. I hereby release and discharge LSUHSC-NO and its officers, directors, employees and students of any liability and the undersigned will hold them harmless for complying with this Authorization.

_____

Signature Date

Relationship to Patient

- ◉ Patient
- Parent
  - ○ Biological
  - ○ Adoptive
  - ○ Foster
- ○ Guardian
- ○ Other (please specify) _____

ASD-ID Clinic Intake Form

Please complete this form to the best of your ability. We recognize that you may not have the answers to all questions. If you feel that there is not enough room or that you would like to elaborate further about a particular topic, please feel free to include it at the space provided at the end of the form. All information requested in this form is important and will allow us to provide you with the most accurate diagnosis and care plans. Thank you for taking the time to complete it. If you have questions about completing this form or the process for the clinic, please contact Tiffany Williams at twil54@lsuhsc.edu.

Reasons for Evaluation/Treatment

What are your primary patient concerns?

What do you hope to gain from the evaluation services provided by the ASD-ID Clinic?

Identifying Information and Healthcare Provider

Patient's Name

Patient's Date of Birth

Name of Person Completing Form

Your Relationship to Patient

Parent
- (●) Biological
- ( ) Adoptive
- ( ) Foster

( ) Guardian

( ) Other (please specify) _____

Please answer the following questions about the patient's living situation:

☐ Patient's Parents Divorced/Separated

If divorced/separated, who is responsible for medical decisions for the child?

(●) Joint ( ) Sole

If sole, which parent? _____

With whom does the child reside?

Household 1: _____% time

Name of Parent/Guardian #1

Name of Parent/Guardian #2

Names, ages, and relationship to child of all other individuals in the home:

Household 2 (if applicable): _____% time

_____
Name of Parent/Guardian #1

_____
Name of Parent/Guardian #2

Names, ages, and relationship to child of all other individuals in the home:

☐ Both parents are aware of services being sought at LSUHSC ASD-ID clinic

_____
If child has a guardian *ad litem,* provide their name

Names and ages of siblings not living with the child:

_____
Primary language (if not English)

_____
Percent time child is exposed to non-English languages

Race (from US Census List):

- ○ White
- ○ Black/African American
- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Native Hawaiian or Pacific Islander
- ○ More than one race
- ◉ Not in list/Prefer not to answer

Clarification of Multiple or Other Race: _____

Hispanic refers to the ethnic communities of Spain or any Spanish-speaking country. A person from any race can be Hispanic.

Ethnicity:

- ○ Hispanic
- ○ Non-Hispanic
- ◉ Prefer not to answer

Primary Care Physician

Clinic Name | Phone Number

Clinic Address

City | State | Zip

Medical History

Has the patient ever had or been diagnosed with any of the following conditions?

- ☐ Hearing Loss
- ☐ Vision or Eye Problems
- ☐ Birth Defects
- ☐ Multiple Ear Infections
- ☐ Tics/Movement Disorders
- ☐ Neurofibrosis
- ☐ Autism/ASD
- ☐ Chronic Stomach/Bowel Problems (e.g., constipation, diarrhea, reflux, vomiting)
- ☐ Chronic Heart Conditions/Disease
- ☐ Lung Disease (asthma, other)
- ☐ Kidney/Bladder/Genital Problems
- ☐ Chronic Skin Problems
- ☐ Hormone/Growth Problems
- ☐ Other Medical Conditions
- ☐ Seizures
- ☐ Sleep Problems
- ☐ Anxiety
- ☐ Frequent or Chronic Headaches
- ☐ Allergies (environmental, seasonal)
- ☐ ADHD/ADD
- ☐ Head Abnormalities
- ☐ Genetic Disorders (e.g., Fragile X, Tuberous Sclerosis, Down syndrome)
- ☐ Depression
- ☐ Mania/Bipolar Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia
- ☐ Other Psychiatric Illnesses

If you answered “Yes” to any of the above, please explain:

Prior Medical Evaluations

Has the patient had any of the following evaluations

Evaluation	**Normal**	**Abnormal**	**No Evaluation**
Audiological Evaluation	○	○	◉
Vision Evaluation	○	○	◉
Head Imaging (MRI, CT, or Ultrasound)	○	○	◉
EEG	○	○	◉
Genetic Testing	○	○	◉
Other evaluations, procedures, or results	○	○	◉

If any of the above were “Abnormal,” please explain:

Has the patient ever been hospitalized? If so, please explain:

Has the patient had any surgeries? If so, please explain:

Are the patient’s immunizations up to date? ○ Yes ○ No ◉ Unknown

Medications & Biomedical Interventions

Is the patient currently taking any medications (prescribed or over the counter), vitamins, or supplements?

Medication, Vitamin, or Supplement Name	Purpose	Date Started	Side Effects

If the patient has special dietary needs, please explain:

Please list any other biomedical interventions:

If the patient is allergic to any foods, please explain:

If the patient will avoid any foods (for reasons other than his/her allergy), please explain:

If the patient has strong preferences for specific foods or food types, please explain:

Pregnancy & Birth History

For the purposes of this section, the terms *parent, mother,* and *father* refer to the child's biological parents.

How old were the parents at the time of the child's birth?

Father's Age at Time of Birth _____ Mother's Age at Time of Birth _____

How many times has the mother been pregnant? _____

How many of the mother's pregnancies resulted in live births? _____

	Yes	No	Unknown
1. Were there fertility treatments to become pregnant with the patient?	○	○	◉
2. Was the patient part of a multiple-birth pregnancy? (e.g., twins)	○	○	◉
3. Did the birth mother take any medications, vitamins, or supplements during pregnancy? If yes, please explain below.	○	○	◉
4. Did the birth mother use any alcohol, tobacco, or recreational drugs during pregnancy? If yes, please explain below.	○	○	◉
5. Were there any difficulties during pregnancy? If yes, please explain below. (e.g., bleeding, fever, infections, abdominal trauma, decrease in fetal movements)	○	○	◉

If "Yes" to any of the above, please explain:

Labor & Delivery and Neonatal Course

Was Pitocin® used to induce or augment this labor? ○ Yes ○ No ◉ Unknown

The delivery was: ○ Vaginal ○ C-section ◉ Unknown

If by C-section, reason performed:

Please provide the following information about the patient's birth measurements:

Birth weight: ◉ _____ Pounds _____ Ounces ○ _____ Grams

APGAR scores (if known): _____ at 1 month _____ at 5 months

Was the patient born premature? ○ Yes ○ No ◉ Unknown

If yes, how many weeks premature? _____

Were there any complications during labor or delivery? ○ Yes ○ No ◉ Unknown

Was any resuscitation required, or was the patient admitted to the NICU?
○ Yes ○ No ◉ Unknown

If yes, how old was the client when discharged? _____ days

Did the patient experience any problems while still in the hospital? (e.g., feeding problems, breathing difficulties, infections, jaundice, seizures) ○ Yes ○ No ◉ Unknown

If "Yes" to any of the above, please explain:

Family History

Please indicate if anyone in the patient's biological family ever had any of the following conditions (if so, please specify which family member, such as "mother," "maternal grandmother," "paternal uncle," etc.)

Condition	**Family Member**
Vision Problems	
Epilepsy/Seizures	
Genetic Disorders	
Multiple Miscarriages/Stillbirths	
Chronic Illness	
Intellectual Disability	
ASD	
Anxiety	
ADHD/ADD	
Bipolar Disorder	
Psychotic Episodes	
Child Abuse	
Hearing Problems	
Tourette's Syndrome	
Birth Defects	
Childhood Deaths	
Neurological Disease	
Learning Difficulties	
Speech & Language Delays	
Obsessive Compulsive Disorder	
Depression	
Schizophrenia	
Suicide	
Delinquency	
Other	

Developmental History

Has the patient accomplished each of the following developmental milestones? If yes, then indicate the approximate age.

Milestone	**Approximate Age**
Smiling when smiled at	
Pointing	
Walking independently	
First Words other than “Mama”/”Papa”/ ”Dada”	
Frrst phrases of 2-3 words	
Toilet Training: Bladder	
Toilet Training: Bowel	
Toilet Training: Night	
Use of Spoon or Fork	

Has the child ever had loss or regression of a previously learned skill? If yes, please explain:

Educational History

If the child is currently enrolled in school, please provide the following information:

School Name

School District Program/Grade Level

Is the patient receiving, or has the patient received, special services or accommodations at school? If yes, please explain what type (e.g., IEP, IFSP, 504 Plan).

Please list any school testing and/or other evaluations of the patient's learning skills.

A. Name of Provider/Agency:
Type of Evaluation:
Date(s):
Result:

B. Name of Provider/Agency:
Type of Evaluation:
Date(s):
Result:

Has the patient experienced any challenges related to reading, math, or writing? If yes, please explain.

Are there concerns around the patient's organization, flexibility, or attention? If yes, please explain.

Behavioral & Social History

Please describe any behavioral concerns you have at this time:

Does the patient make friends easily? If not, please explain:

Are there any concerns regarding the patient's social skills or interests? If so, please explain:

Are there any concerns regarding anxiety and/or depression? If so, please explain:

Has the patient been exposed to any form of abuse, neglect, or domestic violence? If so, please explain:

Has the patient experienced any recent significant stressors (e.g., moves, losses)? If so, please explain:

Are there any concerns regarding any of the following areas?

Area	**If concerns, please explain:**
Responding to sound	
Responding to touch	
Responding to light	
Emotional reactions/regulation	
Aggression toward others	

Are there any concerns regarding any of the following areas?

Area	**If concerns, please explain:**
Self-injuring behaviors	
Difficulty with transitions	
Understanding social cues (e.g., facial cues, gestures)	
Eye contact	
Inappropriate conversations	
Inappropriate behavior	
Ritualistic behavior	
Repetitive behavior (e.g., rocking, hand-flapping)	
Fixation (e.g., computers, certain TV shows, watching spinnning toy)	
Toileting	
Other concerns	

What are the patient's interests and hobbies?

What are some of the patient's strengths?

Additional Evaluations and Interventions

Has the patient ever been seen by an occupational therapist, speech and language therapist, psychiatrist, psychologist, or other mental health counselor?
○ Yes ○ No ◉ Unknown

A. Specialist Name: _____

Type of Specialist: _____

Date of Evaluation: _____

Purpose of Evaluation/Services: _____

Result of Evaluation: _____

B. Specialist Name: _____

Type of Specialist: _____

Date of Evaluation: _____

Purpose of Evaluation/Services: _____

Result of Evaluation: _____

C. Specialist Name: _____

Type of Specialist: _____

Date of Evaluation: _____

Purpose of Evaluation/Services: _____

Result of Evaluation: _____

Additional Comments

Please feel free to discuss any questions or concerns not covered above or to elaborate on anything in the space below: