Spinal Cord Optimization Program Application for Admission

PATIENT INFORMATION

Please print. Fill in all blanks.

PATIENT - First Name	Middle Initial	Last Name	Father's Name
Date of Birth	Gender	Social Security #	Mother's Name

REFERRING DOCTOR or FAMILY PHYSICIAN – Name	Ref. Dr.'s Phone # (with area code)	Ref. Dr.'s Fax # (with area code)	
Referring Doctor's Address	City	State	Zip Code

CUSTODIAL PARENT/GUARDIAN – Name (if different from above)			Relationship to Patient	
Address	City	State	Zip Code	County
Employer	Home phone (with area code)	Work phone (with area code)	Cell phone (with area code)	

NEXT OF KIN – Name		Relationship to Patient	
Address	City	State	Zip Code
Employer	Work phone (with area code)	Home phone (with area code)	Cell phone (with area code)

MEDICAID OR DDSD FUNDING

Medicaid Number	Case Manager	Phone Number

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY – Name	Insured's Name	Insured's Date of Birth	Insured's SS#	
Case Manager	Phone Number			
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address	City	State	Zip Code	

SECONDARY INSURANCE COMPANY – Name	Insured's Name	Insured's Date of Birth	Insured's SS#	
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address	City	State	Zip Code	

Is your child adopted? Yes/No If yes, complete the following as completely as possible.

PREGNANCY

Pregnancy with this patient was: ☐ Normal ☐ With Complications (explain)

____

____

Any medical conditions that are in the family? (asthma, ADHD, heart disease, seizures,)

____

____

Who lives in the home with the patient currently?

____

____

Who is the primary caregiver for your child?

____

____

What are your main goals for an admission to the program?

____

____

MEDICAL HISTORY - ATTACH MOST RECENT HISTORY AND PHYSICAL (H&P) AND IMMUNIZATION RECORD

Current diagnosis/problems or concerns: ____

____

____

Level of Spinal Cord Injury:____

Current bladder program (mode, catheter size, frequency, and who performs cath)________________________

____

Current bowel program (mode, medication, frequency, and who performs bowel program interventions)__________

____

____

Current medications-please bring you child's current medications at the time of admission:

Medication	Dose	Route	Time given/frequency
(ex:) Keppra	5 mg	Gtube	8 am and 8 pm

Home Pharmacy: Name ________________________________Phone Number: _________________________

Respiratory medications-please bring your child's current respiratory medications at the time of admission:

Medication	Dose	Route	Time given/frequency:
(ex:) Albuterol	Two puffs	By mouth	As needed

Airway clearance:

Treatment	Frequency	Other
(ex) Vest treatment	Twice a day	15 minutes

Major illnesses and hospitalizations: ____

____

____

____

Allergies: ____

____

Surgical procedures and dates: ____

____

____

____

____

Current diet: ____

Current height: __________________________________ Weight: ______________________________

Are immunizations up to date? Flu shot? ____

Seizures: Y/N If yes, frequency: ____

What does child do during seizure: ____

Rescue seizure medications: ______________________________

Does your child experience autonomic dysreflexia? If yes, what medications or interventions are used? ________________

____

______________________________/

Tracheostomy size/type: ____________________ Last change: ___________ Frequency changed: ____________________

Non-invasive/invasive ventilation: ____________________ Ordered Settings: ______________________________

Oxygen requirements: ______________________________

<u>EDUCATION HISTORY –</u> ATTACH COPY OF CURRENT IEP (Individual Education Plan)

Is your child currently attending school? ☐ Yes ☐ No

If yes, where? ______________________________

Has your child been evaluated for or placed in any special classes (i.e., lab tutoring, remedial instructions, etc.)? ☐ Yes ☐No

If yes, what services does he/she receive and how often? ______________________________

____

Does your child have a plan for transitioning through High School?______________________________

Has your child had a Visual Screening? ☐ Yes ☐ No

Results: ______________________________

Has your child had a Hearing Screening? ☐ Yes ☐ No

Results: ______________________________

What are your child's preferred leisure/play time activities? ______________________________

____

<u>REHABILITATION HISTORY-</u> ATTACH A COPY OF CURRENT OUTPATIENT THERAPIES GOALS, EVALUATIONS AND PLAN OF CARE

Has your child previously **<u>received therapy</u>**? ☐ Yes ☐ No

If yes, please provide the following information, beginning with the most recent:

Dates Attended	**Location of Treatment**	**Therapy Type PT, OT, ST, MT** Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST) Music Therapy (MT)	**Therapist and Telephone #**	**Frequency of Treatment**
to				
to				
to				
to				
to				

Is your child currently using any adaptive equipment?

☐ Yes ☐ No If yes, check all that apply

☐ Wheelchair ☐ Walker
☐ Stander ☐ Positioning equipment
☐ Splints/braces ☐ Glasses
☐ Switches ☐ Hearing aide
☐ Communication device ☐ Speaking valve
☐ Feeding equipment ☐ Bathing equipment
☐ Other: (specialty bed, etc.)____

If your child wears splints or braces, what is wearing schedule? ______________________________

What company orders and fits your child's equipment? __________________________________

What are your child's current functional abilities? ____________________________________

____

What are your child's current functional limitations? ____________________________________

____

Please mark all of the following that your child is able to perform at this time:

☐ head control ☐ standing ☐ self feeds
☐ rolling ☐ cruising
☐ sitting with support ☐ walking with assistance
☐ sitting without support ☐ walking without assistance
☐ crawling ☐ eating by mouth

Please describe your child's typical day/schedule

____

____

____

____

____

Does your child have any special transportation needs? (medical transport, medical car seat, etc.)____________

____

____

Which of the following services do you feel would most benefit your child during admission? Any specific goals/concerns for each therapy?

Physical therapy ____

____

Occupational therapy ____

____

Speech-language pathology ____

____

Music therapy ____

____

Education____

____

Recreation therapy____

____

SOCIAL SERVICES

Are there any services, equipment or information that would make caring for your child at home easier?

____

____

____

____

Please list previous stays your child has had out of your home besides The Children's Center (i.e. evaluation, etc.).

Facility: ____ Dates: _______________

Reason: ____

Facility: ____ Dates: _______________

Reason: ____

Please return completed packet to The Children's Center Rehab Hospital 10-14 days prior to admission.

The Children's Center Rehab Hospital
Attn: Admissions
Donald W. Reynold's Complex
6800 NW 39th Expressway
Bethany, OK 73008 or
Referrals@tccokc.org or
Fax: 1-844-785-7681
Thank you for allowing us to care for your child.