the children's center
REHABILITATION HOSPITAL

Short-Term Evaluation 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, please answer following questions to the best of your knowledge.**

PREGNANCY

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

_____

_____

_____

FAMILY HISTORY

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?

_____

MEDICAL HISTORY:

Current diagnosis/new problems or concerns: _____

_____

_____

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: (orthopedic, ENT, etc.) _____

_____

_____

_____

_____

Current diet: _____ Formula: _____ Volume: _____

Times: _____ Additional water: _____ Modifiers (Benefiber, etc.): _____

Current height: _____ Weight: _____

Are immunizations up to date? Flu shot? _____

EDUCATION HISTORY – 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? _____

_____

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

Results: _____

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

Results: _____

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

Has your child previously **received therapy**? ☐ 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
☐ Stander
☐ Splints/Braces
☐ Switches
☐ Communication device
☐ Feeding equipment
☐ Walker
☐ Positioning equipment
☐ Glasses
☐ Hearing aide
☐ Speaking valve
☐ Bathing equipment

☐ Other, (specialty bed, etc)

_____

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

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
☐ rolling
☐ sitting with support
☐ sitting without support
☐ crawling
☐ standing
☐ cruising
☐ walking with assistance
☐ walking without assistance
☐ eating by mouth

Please describe your child's typical day/schedule:

_____

_____

_____

_____

_____

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 _____

☐ 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.