stmary's
Healthcare System for Children

THE CINDY AND TOD JOHNSON
CENTER FOR PEDIATRIC FEEDING DISORDERS

Cindy & Tod Johnson Center for Pediatric Feeding Disorders
29-01 216th Street
Bayside, NY 11360
Phone: 718 281-8541
Fax: 718 281-8505

Dear Caregiver(s),

Thank you for your recent inquiry about the Cindy and Tod Johnson Center for Pediatric Feeding Disorders. Enclosed is an application that must be completed and returned in order to receive a feeding evaluation appointment. Please complete the application and return it to the feeding center along with the growth chart and any pertinent medical records. In addition, a letter of medical necessity must be obtained from your pediatrician or GI doctor. Once we have received all the necessary paperwork we will call you to schedule the feeding evaluation. Please note, clinic appointments are held on Tuesday mornings. After the child attends the evaluation it will be determined if they qualify for the feeding services at the Center for Pediatric Feeding Disorders at St. Mary's Hospital for Children.

All documentation must be received by the center before the appointment can be scheduled:

- Completed application packet
- Parent Mealtime Action
- Growth Chart
- Letter of Medical Necessity
- Notice of Privacy Practices (signed last page)
- HIPAA
- Photo Consent

If applicable:

- Gastroenterology reports: Upper GI, Endoscopy, Swallow study, Esophagram
- Blood and/or biopsy results
- Allergist report
- Pulmonologist report
- Record of Hospitalizations or any other medical procedures
- Early Intervention reports
- School related service reports
- MRI or CAT scans

All information can be faxed, e-mailed or mailed to the center. If you have any questions about the application process, please call Program Coordinator, Jamie Russell, at (718) 281-8541 or e-mail jrussell@stmaryskids.org.

Sincerely,

Program Coordinator

Cindy & Tod Johnson Center for Pediatric Feeding Disorders
ST. MARY'S HOSPITAL FOR CHILDREN
29-01 216th Street
Bayside, NY 11360
718-281-8541

PATIENT APPLICATION (for children under 24 months)

Please complete the following intake form. Mark N/A if the question does not apply to your child

INTAKE INFORMATION:

Patient (Last): ________________________ (First): _______________ Date of Birth: ________________ Today's date: ________

Gender: ❑ Male ❑ Female Caregiver Name: ____

Child's most recent height:___________ weight:____________ When were they taken: _____/______/______

Home Address: ____

City, State, Zip: ____

Home Telephone Number: ___________________________ Cell Phone Number: ______________________________

Email address: ____________________________________ Patient's Social Security:____________________________

Ethnicity origin (or Race): Please specify your child's ethnicity.
❑ White ❑ African American ❑ Latino or Hispanic ❑ American Indian or Alaskan Native
❑ Native Hawaiian or Pacific Islander ❑ Asian ❑ Other

Family Members

Please list all the people that live in your household:

Name	Age	Relationship to Child	Occupation	Education

Insurance Information

Primary Insurance Name: ______________________________________ Policy Number: _________________________

Name of Policy Holder: ____ Policy Holder DOB: ______________________

Policy Type: ___________________________________

Secondary Insurance Name: _____________________________________ Policy Number: _________________________

Name of Policy Holder: ____ Policy Holder DOB: ______________________

Policy Type: ___________________________________

Therapeutic Service Information:

Contact Person at education institution: (EI coordinator, CPSE/CSE administrator) ______________________________

Contact phone Number: ___________________________ Contact Fax Number: ________________________________

Contact Address: ____

List therapeutic services and mandates: ____

Therapist names and numbers: ____

____

____

____

____

<u>School Information</u>:

Name of school: ____

Contact Person at education institution: ____

Contact phone Number: ___________________ Contact Fax Number: ______________________________

Contact Address: ____

<u>Physician's Information</u>

Primary Care Physician: ____

PCP Address: ____

City, State, Zip: ____

PCP Telephone Number: _______________________ PCP Fax Number: ______________________________

Gastroenterologist:: ____

Address: ____

City, State, Zip: ____

GI Telephone Number: ______________________________GI Fax Number: _____________________________

Specialist: ____

Specialist Address: ____

City, State, Zip: ____

Specialist Telephone Number: ______________________ Specialist Fax Number: ____________________

Specialist: ____

Specialist Address: ____

City, State, Zip: ____

Specialist Telephone Number: _____________________ Specialist Fax Number: ______________________

Specialist: ____

Specialist Address: ____

City, State, Zip: ____

Specialist Telephone Number: _______________________ Specialist Fax Number: _________________

BIRTH HISTORY:

How many weeks was the baby born and at what hospital? ____
__________________________(i.e., 40 weeks is full term)

How much did your baby weigh at birth? _________________ Height: ___________

Born via: vaginal OR caesarian section

Did you have any of the following problems with: pregnancy, labor, or delivery?

❑ Gestational diabetes ❑Preterm labor ❑ Eclampsia/Pre-eclampsia
❑ Abnormal ultrasound ❑ Infection
❑ Other (specify)____

Was your baby admitted to the NICU? _______ If yes, how long was he/she there? ____________________________________

Did your baby have any of the following problems in the nursery?

❑ Gastroesophageal reflux (GER) ❑ Mechanical ventilation ❑ Bronchopulmonary dysplasia (BPD)
❑ Apnea ❑ CPAP therapy ❑ Necrotizing enterocolitis (NEC)
❑ Feeding and growth issues ❑ Tube feedings ❑ Intraventricular hemorrhage (bleeding in brain)
❑ Other (specify) _______________________________

Please describe:
____
____
____
____
____

GENERAL HISTORY:

Feeding History:

Was your child breast-fed, bottle-fed or other? (Note any problems)
____
____

As an infant did your child switch to different formula? Yes or No
If yes please list which ones and how they were tolerated.
____
____

As your child grew did they tolerate larger volumes of formula/breast milk? ____

At what age did your child eat baby cereal or baby food? (Note any problems)
____
____

At what age did your child start eating solid/chewable food? (Note any problems)
____
____

At what age did your child transition from baby formula to milk or equivalent? (Note any problems)
____
____

Has your child received feeding therapy? If yes who was the treating therapist? Did the child make progress?
____
____
____
____

Developmental Milestones:

At what age did your child: Sit________ Crawl__________ Stand ________ Cruise________ Walk_________

Babble________ Say single words________ Sentences__________ Follow directions__________

MEDICAL HISTORY

List any major hospitalization or illnesses: (include dates)
____
____
____
____
____

List any surgeries or outpatient procedures: ____
____
____
____
____

Have any of the following medical tests been done?

❑ Upper GI series ❑ Milk scan ❑ Modified barium swallow study ❑ Head CT scan
❑ Endoscopy ❑ PH probe ❑ Genetic (chromosome) testing ❑ Head MRI scan
❑ Bone age film/x-ray ❑ Allergy testing ❑ Other (specify) ____________________________________

List medical tests completed in the last year:
(i.e. upper GI, MBS, FEES, x-rays, MRI, vision, hearing, cardiac, pulmonary)
____
____
____
____

PEDIATRIC CARE:

Does your child currently have, or has your child had, any of the following issues? Check the appropriate box(es).

Current	Previous	Type of Issue	Current	Previous	Type of Issue
		Autism, PDD, or Asperger's			Gastroesophageal Reflux
		Developmental or Speech Delay			Chronic constipation
		ADHD or Learning Disability			Chronic diarrhea
		Traumatic Brain Injury			Food Allergies
		Mental Retardation			Lactose Intolerance
		Asthma or lung problems			Seasonal Allergies
		Endocrine disorder			Heart problems
		Anxiety Disorder or OCD			Diabetes, Type I or Type II
		Cerebral Palsy			Delayed Gastric Emptying
		Spina Bifida			G-tube or NG-tube feeding
		Seizure Disorder			Kidney Disease
		Cleft palate or lip			Tracheomalacia
		Vision Problems			Hearing Problems
		Prematurity			Eosinophilic Esophagitis
		Metabolic Disorder			Other condition:

Current medications and dosages:
____

List all known allergies/intolerance (i.e. food, drugs, material):
____

Does you child currently have any GI issues? ❑ Yes ❑ No

If your child vomits, on average what is the volume of vomit per episode?
____

When does vomiting occur? (i.e., at meals, after meals, when upset)
____

How many bowel movements a day does your child have? __________ Are the stools runny, soft, formed, hard, pebbles? (specify)____

Does your child complain of abdominal pain? If yes, how frequently, associated to what?

____

How often does your child experience problems with diarrhea or constipation?
____

If they have vomiting, diarrhea or constipation what treatments have their doctors recommended?
____

NUTRITIONAL INFORMATION:

Does you child currently see a dietician/nutritionist? ❑ Yes ❑ No If yes name: ___________________________________

Does your child take vitamins or supplements: ❑ Yes ❑ No Please list: ______________________________________

Your child's appetite is best described as:

❑ Poor ❑ Fair ❑ Good ❑ Excellent ❑ Eats too much

TUBE FEEDS:

Has your child ever had?

❑ G-tube ❑ J-tube ❑ NG-tube ❑ NJ-tube ❑ GJ-tube

Dates of use: from: ____________ to: __________

Does your child currently have:

❑ G-tube ❑ J-tube ❑ NG-tube ❑ NJ-tube ❑ GJ-tube

Formula name: _____________________________ How many calories per ounce is the formula? ___________________

Continuous feeding:

How much per hour:__________________ Length of feeding (start time/stop time?) _____________________________

Bolus feeds:

What is the bolus schedule? ____

Volume per bolus________________________ How long does a bolus feed take? ______________________________

Has your child had difficulty gaining weight on the current tube feeding schedule? ❑ Yes ❑ No

How many times per day does your child vomit during or within one hour of tube feeding?
❑ 0 times ❑ 1-3 times ❑ 4-6 times ❑ 7-9 times ❑ 10 or more times

How many times per week does your child gag or retch during or within one hour of tube feeding?
❑ 0 times ❑ 1-3 times ❑ 4-6 times ❑ 7-9 times ❑ 10 or more times

How many times per week does your child cry during or within one hour of tube feeding?
❑ 0 times ❑ 1-3 times ❑ 4-6 times ❑ 7-9 times ❑ 10 or more times

How often does your child need to be vented during the day and at what times?_________________________________

Have you ever increased the rate of tube in the last 3-6 months and what happened?
____
____

Other comments regarding tube feedings:
____
____

CURRENT FEEDING/DRINKING SKILLS:

Which of these does your child consume? (Check all that apply):

❑ Breast milk	❑ Baby cereal	❑ Blenderized foods
❑ Formula	❑ Ground meats	❑ Strained baby food
❑ Milk	❑ Liquids/soup	❑ Table foods
❑ Juice	❑ Creamy foods	❑ Crisp foods (crackers)
❑ Water	❑ Chewy food (meat)	❑ Crunchy food (celery)

List the liquids your child will consistently drink: ____
____

List the food your child will consistently eat: ____
____

How does your child indicate he/she is hungry?
____
____

Does your child eat on a schedule? ❑ Yes ❑ No Where does your child eat: (e.g. table, high chair) ______________

Does you child have any problems with: (Check all that apply)

❑ Drooling	❑ Sucking from a bottle or straw
❑ Tongue control	❑ Biting
❑ Lip control	❑ Chewing
❑ Swallowing	❑ Coughing
❑ Teeth grinding	❑ Blowing
❑ Gagging	❑ Impaired sound production
❑ Drinking from a cup	❑ Other:

CHILD PREFERENCE:

Child favorite activities: ______________________________Child's favorite toys: __________________________________

What feeding problems does your child currently have?

_____ Food Refusal (refusing all or most food)

_____ Food Selectivity by Texture (eating only textures not developmentally appropriate)

_____ Food Selectivity by Type (eating a narrow variety of foods)

_____ Oral Motor Delays (problems with chewing, lip closure, or tongue lateralization)

_____ Dysphagia (problems with swallowing)

_____ Abnormal preferences (e.g. refuses food if not a certain temperature, eats only certain brands, must have a certain cup or special silverware to eat) Describe:_______ ____

_____ Self-feeding

_____ Other feeding problem (describe)____

1. What feeding issues do you want addressed by the Feeding Program (circle each)?

Increase the volume of food my child eats	Reduce/eliminate diarrhea or constipation	Improve mealtime behaviors
Increase the variety of foods my child eats	Increase weight gain	Decrease vomiting related to eating
Improve oral motor skills	Resolve reflux or other GI issues	Decrease tube feedings
Decrease gagging during eating	Increase the texture of food my child eats	Other:
Improve cup drinking	Self-feeding	

Does your child?

Place an x in the box if your child can perform a skill

	Bring food to his or her mouth		Feeds self using a baby bottle
	Transfer toys or food from one hand to the other		Reach for a spoon when hungry
	Eats finger foods without gagging		Feeds self cookie or cracker
	Puts finger in mouth to move food and keep it in		Uses fingers to rake food toward self
	Uses fingers to self-feed soft, chopped food		Scoops puddings and brings to mouth
	Picks up, dips foods, and brings to mouth		Uses top lip to remove food from spoon

During a typical week, how often do you show each mealtime action? Circle the appropriate number after each action

Parent Mealtime Action	1 = never, 2 = sometimes, 3 = always, N/A = Not applicable			
You continued to offer the bottle even after your baby started to pull away in order to have the baby finish the bottle.	1	2	3	N/A
You used a pillow to prop the bottle while the baby was feeding	1	2	3	N/A
You gave your baby “cheek support” (holding cheeks) while he or she was drinking the bottle.	1	2	3	N/A
You drove your child in the car in order for he or she to take a bottle	1	2	3	N/A
You cut the nipple of your baby’s bottle so he or she would eat faster	1	2	3	N/A
You put infant cereal in your child’s bottle to increase calories	1	2	3	N/A
You allowed your baby to hold his/her own bottle	1	2	3	N/A
You continued to offer the bottle when your baby was turning his or her head	1	2	3	N/A
You continued to offer the bottle even after your baby started to pull away in order to empty the bottle.	1	2	3	N/A
You followed your baby’s cues (e.g. rooting to his or her hands) that told you he or she was hungry	1	2	3	N/A
You put infant cereal in your child’s bottle to help with spitting up	1	2	3	N/A
You fed your baby small amount (e.g. 1 oz) every hour rather than larger amounts every 2-3 hours.	1	2	3	N/A

You gave your child a favorite food as a reward for good behavior	1	2	3	N/A
Your baby was crying while you were offering the bottle	1	2	3	N/A
You put baby foods (Stage 2 or purees) in the bottle to introduce new textures or tastes.	1	2	3	N/A
Parent Mealtime Action	1 = never, 2 = sometimes, 3 = always, N/A = Not applicable			
You allowed the child to watch videos or TV when eating	1	2	3	N/A
You offered your child mostly foods he or she had eaten well in the past	1	2	3	N/A
You stopped your child from eating too much	1	2	3	N/A
You offered the child a toy or favorite activity as a reward for eating	1	2	3	N/A
You tried to have a consistent meal/snack schedule for your child	1	2	3	N/A
You offer your child another food if he or she refuses a particular food at meals	1	2	3	N/A
You mostly fed your child instead of having your child self feed	1	2	3	N/A
You allowed your child to have juice in his or her sippy cup or bottle	1	2	3	N/A
You gave your child a bottle because he or she did not eat his/her meal	1	2	3	N/A
You told the child how good the food would taste if he/she tried it	1	2	3	N/A
You told the child that his/her friends or siblings like the food	1	2	3	N/A
You gave the child vegetables each day	1	2	3	N/A
You gave the child fruits each day	1	2	3	N/A
You made changes to the child's food to lower fat	1	2	3	N/A
You ate fruit each day	1	2	3	N/A
You ate vegetables each day	1	2	3	N/A
You made changes to your own food to lower fat	1	2	3	N/A
You insisted the child eat when he/she was sleepy, not feeling well	1	2	3	N/A
You insisted the child eat when he/she was emotionally upset	1	2	3	N/A
You offered some of each food from the family meal	1	2	3	N/A
You let your child eat whenever he or she wanted to	1	2	3	N/A
You reprimanded your child when he or she didn't take a bite	1	2	3	N/A
You let your child decide when he or she was finished eating	1	2	3	N/A
You fed your child extra just to be sure he or she had enough to eat	1	2	3	N/A
You gave your child a squeeze pouch instead of spoon feeding	1	2	3	N/A
The first thing you did when your child was fussy was feed him or her	1	2	3	N/A
You put infant cereal in your child's bottle so he or she would sleep longer at night	1	2	3	N/A
You forced a spoon in your child's mouth because he or she would not open for a bite	1	2	3	N/A
You hid the taste of a new food inside a preferred food	1	2	3	N/A
You praised your child for eating	1	2	3	N/A
You restricted your child from eating too much of a specific food	1	2	3	N/A
You had to hold down your child's arms because he or she was pushing you away during a meal	1	2	3	N/A
You only allowed your child to eat at specific times	1	2	3	N/A
You let your child decide when he or she was finished eating	1	2	3	N/A

You gave your child bottles or sippy cups of milk between meals	1 2 3 N/A
You offered your child multiple foods during a meal because he or she cried and pushed away the first food	1 2 3 N/A
You made your child clean his or her plate or eat a specific portion	1 2 3 N/A
Parent Mealtime Action	1 = never, 2 = sometimes, 3 = always, N/A = Not applicable
You allowed your child to play with toys or other items, like your phone, during meals	1 2 3 N/A
You allowed your child to have soda in his or her bottle or sippy cup	1 2 3 N/A
You allowed your child to eat snacks whenever he or she wanted	1 2 3 N/A
You retried new foods if they were first rejected	1 2 3 N/A
You sat with the child during a mealtime, but did not eat	1 2 3 N/A
You give bottles or feed your child when he or she is sleeping or going to sleep to get your child to eat	1 2 3 N/A

My child currently breastfeeds Yes No If yes, estimate how many times in a 24 hour period _________

If your child previously breastfed, for how many months did your child breastfeed? __________

When bottle feeding, what nipple type/flow rate does your infant use? ________________________

How many bottles does your infant take each day? ____

Does your baby feed on a schedule, if so what is that schedule? ______________________________

On average, how long is your baby's typical feeding? ___________________________

Have you tried different formula types, if so which? ______________________________

Think about mealtimes with your child over the past 6 months. Rate the following items according to how often each occurs, using the following scale:

Never/Rarely	Seldom	Occasionally	Often	At Almost Every Meal
1	2	3	4	5

Then, circle **YES** if you consider the item to be a problem or **NO** if you think it is not a problem.

	How often did it occur?	Do you consider this a problem?
My child cries or screams during mealtimes.	1 2 3 4 5	YES NO
My child turns his/her face or body away from food.	1 2 3 4 5	YES NO
My child remains seated at the table until the meal is finished.	1 2 3 4 5	YES NO
My child expels (spits out) food that he/she has eaten.	1 2 3 4 5	YES NO
My child is aggressive during mealtimes (hitting, kicking, scratching others).	1 2 3 4 5	YES NO
My child displays self-injurious behavior during mealtimes (hitting self, biting self).	1 2 3 4 5	YES NO
My child is disruptive during mealtimes (pushing/throwing utensils, food).	1 2 3 4 5	YES NO
My child closes his/her mouth tightly when food is presented.	1 2 3 4 5	YES NO
My child is flexible about mealtime routines (e.g. times for meals, seating arrangements, place settings	1 2 3 4 5	YES NO
My child is willing to try new foods.	1 2 3 4 5	YES NO
My child refuses to eat foods that require a lot of chewing (e.g. eats only soft or pureed foods)	1 2 3 4 5	YES NO

My child dislikes certain foods and won't eat them.	1 2 3 4 5	YES NO
My child prefers the same foods at each meal.	1 2 3 4 5	YES NO
My child accepts or prefers a variety of foods.	1 2 3 4 5	YES NO
My child prefers "crunchy" foods (e.g. snacks, crackers)	1 2 3 4 5	YES NO
My child prefers to have food served in a particular way.	1 2 3 4 5	YES NO
	How often did it occur?	Do you consider this a problem?
My child prefers only sweet foods (e.g. candy, sugary cereals).	1 2 3 4 5	YES NO
My child prefers food prepared in a particular way (e.g. eats mostly fried foods, cold cereals, raw vegetables)	1 2 3 4 5	YES NO

For Children 12 months or younger, Please read the following statements and mark the most appropriate box.

	Never	Rarely	Sometimes	Often	Always
The majority of my baby's nutrition and hydration comes from formula and/or milk	□	□	□	□	□
My baby shows actives cues (for example, rooting to his or her hands) that tell me when he or she is ready to eat	□	□	□	□	□
My baby is happy and smiling while feeding	□	□	□	□	□
My baby is crying and uncomfortable while feeding	□	□	□	□	□
My baby always appears to be hungry and ready for another bottle	□	□	□	□	□
My baby would drink more ounces than recommended by his or her pediatrician if allowed to.	□	□	□	□	□
Even when my baby had just eaten well, s/he was happy to feed again if offered.	□	□	□	□	□
If given the chance, my baby would always be feeding.	□	□	□	□	□
My baby acts as if he or she is still hungry after a feeding (crying, rooting to hands)	□	□	□	□	□
My baby could easily take a feed within 30 minutes of the last one.	□	□	□	□	□
My baby finished feeding quickly.	□	□	□	□	□
My baby fed slowly.	□	□	□	□	□
My baby took more than 30 minutes to finish feeding.	□	□	□	□	□
My baby sucked more and more slowly during the course of a feed.	□	□	□	□	□
My baby found it difficult to manage a complete feed.	□	□	□	□	□
My baby stopped actively sucking and started to refuse his or her bottle before it was finished	□	□	□	□	□
My baby drinks more milk than the average for his or her age.	□	□	□	□	□

Current Tube Feeding Information: Type of feeding tube: G- tube J-Tube NG- tube NJ- tube

How is feeding done? Continuous feeding: rate/hour _______ How long does the feeding last? _____

Bolus feeds: What is the bolus schedule? ____

Type of formula used: ___________________

How much does your child receive from tube feeding in 24-hours (please specify formula, water, etc.)?

Please circle the appropriate response

My child eats pureed/blended/strained food (like baby food)	Yes	No
My child eats ground/lumpy food (like scrambled eggs)	Yes	No
My child eats cut up/chunky food (like chopped vegetables)	Yes	No
My child can chew dry, crisp foods (like crackers)	Yes	No
My child eats regular texture meats (like steak)	Yes	No
My child drinks from a straw with little spilling	Yes	No
My child drinks from an open cup with little spilling	Yes	No
My child can use a spoon to feed him/herself without help	Yes	No
My child uses a fork to feed him/herself without help	Yes	No
My child becomes more congested across the course of a meal	Yes	No
My child starts to breath rapidly during meals	Yes	No
My child commonly coughs while drinking	Yes	No

Are there any problems or concerns with? (check all that apply)

	Drooling		Poor sucking
	Poor tongue control		Lack of chewing
	Poor lip control		Vomiting during or after eating
	Swallowing problems		Hypersensitive to temperature, texture, etc.
	Coughing while eating		Gagging during eating

What does your child drink?

Any supplement (e.g. Pediasure, Boost, etc.)? (Circle) Yes No

If yes, which one?___________________________________

How much/day?_________________ounces

What kind of milk (circle)? Whole 2% 1% Skim Soy Rice None Other Type of Milk

How much/day? ____________ounces

Does your child drink juice (Circle)? Yes No

If yes, how much 100% juice per day? ______ ounces

Does your child drink fruit drinks such as Hi-C, Kool Aid, etc.) ? (Circle) Yes No

If yes, how much per day? _____ounces

Does your child drink soda or iced tea? (Circle) Yes No

If yes, how much soda or iced tea per day? _______ ounces

Does your child drink water? (Circle) Yes No

If yes, how much water per day? _______ounces

Please indicate how often your child eats each food: **0** = never, **D** = Daily, **W** = Weekly, **M** = Monthly

If your child eats this food in a lower texture such as baby food, blended food, or ground food, place a √ in the *Low Texture* column.
If you eat this food, place a√ in the *You eat* column

Food	How often: 0,D,W,M	Low Texture: √	You eat: √	Food	How often: 0,D,W,M	Low Texture: √	You eat: √
Milk (white/flavored)				Bacon			
Yogurt				Beef (roast, steak)			
Cottage Cheese				Chicken nuggets/fingers			
Cheese (any type)				Chicken, turkey			
Ice Cream or Sherbet				Ground beef, hamburger			
Pudding				Ham, Pork			
Soy Milk				Hot Dog			
Soy Yogurt				Lunchmeat			
Apple				Sausage			
Applesauce				Shellfish (shrimp, lobster, clams)			
Apricot				Tuna or any fish			
Banana/Plantains				Eggs			
Cranberry Sauce				Beans (e.g. pinto, kidney)			
Grapes				Tofu, soybeans			
Grapefruit				Peanut butter, almond butter			
Kiwi				Peanuts, nuts, sunflower seeds			
Mango				Muffin, bagel, roll			
Nectarines				Cold Cereal			
Oranges/Tangerines				Oatmeal or Hot Cereal			
Peaches				Rice Cereal			
Pears				Poptart or Breakfast Bar			
Strawberries				Bread or pita			
Other berries				Rice, white or brown			
Pineapple				Pasta (spaghetti, ravioli, lasagna)			
Plums				Mac-n-cheese			
Raisins				Crackers			
Watermelon				Pizza			
Other melon				Stuffing or filling			
Broccoli				Peas			
Brussel sprouts				Lima Beans			
Carrots				Tomato			
Cauliflower				Onion			
Celery				Eggplant			
Coleslaw, cabbage				Chocolate			
Corn				Candy (not chocolate)			
Cucumbers				Cookies or brownies			
French fries/tater tots				Donuts or sweet rolls			
Green Pepper				Pie			
Greens (collard, chard)				Cake			
Lettuce				Corn/tortilla chips			
Potato (baked, mashed)				Cheese puffs/curls/doodles			
Sweet potato, yams				Pretzels			
Zucchini				Potato Chips			
Squash				Puffs (i..e Gerber puffs)			

Please list **all** of the food and drink your child actually consumed in the last 24 hours:

Morning

Mid-morning

Noon

Afternoon

Evening or nighttime

stmary's
Healthcare System for Children

THE CINDY AND TOD JOHNSON
CENTER FOR PEDIATRIC FEEDING DISORDERS

RELEASE FOR TAKING & UTILIZING PHOTOGRAPHS, PHOTOCOPIES, TAPE RECORDINGS, FILMS

I am the parent/legal representative of ___________________________________ and hereby grant permission to St. Mary's, it's agents, employees, and any person, firm or organization that St. Mary's may designate or authorize, to take photographs, tape recordings, video tapes and films (collectively, the "materials") of me, other members of my family, and/or the above named minor.

This consent includes the use of the materials with or without my name, other family members' names or my son's/daughter's name and biographical data by St. Mary's or anyone else on its behalf, without limitations as to time or frequency of use, for any or all of the following purposes: newspaper, website, publicity, release of communication to other media, educational/teaching purposes, and use in St. Mary's materials. Other: ______________________________

I grant this consent voluntarily and hereby waive any and all rights I may have to royalties or other compensation in connection with publication or other use of the materials.

Relationship: ☐ Parent ☐ Guardian ☐ Legal Representative ☐ Other: ______________________

Signed: _______________________________________ Date: ________________________

☐ I do not consent to the taking of photographs, tape recordings, videotapes or films of the above named resident/patient.

AUTORIZACIÓN PARA TOMAR Y UTILIZAR FOTOGRAFÍAS, FOTOCOPIAS, GRABACIONES MAGNETOFÓNICAS Y PELÍCULAS

Yo estoy padre o representante legal de ____, y autorizo a St. Mary's, sus agentes, empleados y cualquier otra persona, empresa u organización que St. Mary's pueda designar o autorizar, a que tome fotografías, realice grabaciones magnetofónicas o de video y filme películas (en adelante, los "materiales") de mí, otros miembros de mi familia y/o el residente antedicho.

Esta autorización incluye el uso por parte del St. Mary's o cualquier otro en su nombre, de los materiales, con o sin mi nombre, el nombre de otros miembros de mi familia o el nombre de mi hijo e información biográfica, sin limitación en cuanto a tiempo o frecuencia de uso, para cualquiera de estos fines o todos ellos: periódicos, publicidad, autorización de comunicación a otros medios, propósitos educativos, pedagógicos o docentes. __________________________

Concedo esta autorización voluntariamente y, por consiguiente, renuncio a cualquiera y todos los derechos que pudiera tener en cuanto a regalías u otras compensaciones relacionadas con la publicación o cualquier otro uso de los materiales.

Parentesco: ☐ Padre ☐Tutor ☐ Representante legal ☐ Otro: ________________________

Firma: _______________________________________ Fecha: ________________________

☐ No autorizo la toma de fotografías, ni la realización de grabaciones magnetofónicas o de video ni la filmación de películas del residente antes mencionado.

ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN
St. Mary's Hospital for Children, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:	Date of Birth:	Social Security Number
Patient Address:		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL**, and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line of the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9. (a) Specific information to be released:
□ Medical Record from (insert date) ________________ to (insert date)___________________
□ Entire Medical Record, including resident histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
□ Other: ________________________
____

Include: (Indicate by Initialing)
________**Alcohol/Drug Treatment**
________**Mental Health Information**
________**HIV-Related Information**

Authorization to Discuss Health Information
(b) □ By initialing here ______________I authorize____
Initials — Name of Individual health care provider
To discuss my health information with my attorney, or a governmental agency, listed here:
____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information □ At request of individual □ Other:	11. Date or event on which this authorization will expire:
12. If not the resident, name of person signing form:	13. Authority to sign on behalf of resident:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Name of Representative Authorized by Law (Parent): _______________________________________

____ Date: _____________________
Signature of Representative Authorized by Law (Parent)

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts. (OCA Official Form # 960).**

St. Mary's Healthcare System for Children
St. Mary's Hospital for Children, Inc.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 2003; Revised September 24, 2013; Revised September 4, 2015; Revised August 5, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of St. Mary's health care professionals who provide treatment or care for St. Mary's patients, and affiliated health care providers that jointly perform payment activities and business operations with St. Mary's. A copy of our current notice will always be available in the reception area of all of our sites. You or your personal representative may also obtain a copy of this notice by requesting a copy from St. Mary's staff or **Martha Pellicano, Privacy Officer at (718) 281-8587**.

Generally, when this notice uses the words, "you" or "your," it is referring to the patient which is the subject of patient information. However, when this Notice discusses rights regarding patient information, including rights to access or authorize the disclosure of patient information, "you" and "your" may refer to a minor-patient's parent(s), legal guardian or other personal representative, or, as applicable, an adult patient's personal representative.

If you have any questions about this notice or would like further information, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**.

IMPORTANT SUMMARY INFORMATION

Requirement for Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside St. Mary's Healthcare System. You may also initiate the transfer of your records to another person by completing an authorization form. Your written authorization is required prior to the use or sharing of psychotherapy notes. We will not sell or receive anything of value in exchange for your medical information without your written authorization. Your information will not be used for marketing purposes without your written authorization. If you provide us with written authorization, you may revoke that authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**.

Exceptions to Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception for Treatment, Payment, and St. Mary's Operations.** For more information, see page 3-4 of this notice.

- **Exception for Disclosure to Friends and Family Involved in Your Care.** We will ask you whether you have any objection to sharing information about your health with your friends and family involved in your care. For more information, see page 4 of this notice.

- **Exception in Emergencies or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or city health departments who are authorized to investigate and control the spread of diseases. For more examples, see pages 4-6 of this notice.

- **Exception if Information Does Not Identify You.** We may use or disclose your health information if we have removed any information that might reveal who you are.

How to Access Your Health Information. You generally have the right to inspect and to receive a copy your health information. For more information, please see page 6 of this notice.

How to Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. For more information, please see page 7 of this notice.

How to Keep Track of the Ways Your Health Information Has Been Shared with Others. You have the right to receive a list from us, called an "accounting list," which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on this list, but the list will identify non-routine disclosures of your information. For more information, please see page 7 of this notice.

How to Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. For more information, please see page 8 of this notice.

How to Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you. We will try to accommodate all reasonable requests. For more information, please see page 8 of this notice.

How Someone May Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**.

How to Obtain a Copy of this Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time. To do so, please ask a St. Mary's staff member or **Martha Pellicano, Privacy Officer at (718) 281-8587**. You or your personal representative may also obtain a copy of this notice by requesting a copy from St. Mary's staff.

How to Obtain a Copy of Revised Notices. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information, and we will be required by law to abide by its terms. We will post any revised notice in St. Mary's reception area. You or your personal representative will also be able to obtain your own copy of the revised notice by requesting a copy from a St. Mary's staff member or **Martha Pellicano, Privacy Officer at (718) 281-8587**. The effective date of the notice will always be located in the top right corner of the first page.

How to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**. *No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information about your health condition (such as a disease you may have);
- information about health care services you have received or may receive in the future (such as an operation);
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);
- geographic information (such as where you used to live or work);
- demographic information (such as your race, gender, ethnicity, or marital status);
- unique numbers that may identify you (such as social security number, phone number, or driver's license number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. Treatment, Payment and St. Mary's Business Operations

St. Mary's staff and other health care professionals in the St. Mary's Healthcare System may use your health information or share it with others for the purposes of your treatment or care, obtaining payment for treatment or care, and conducting St. Mary's normal business operations. Your health information may also be shared with affiliated health care facilities and providers so that they may jointly perform certain payment activities and business operations along with St. Mary's. Below are further examples of how your information may be used with your consent.

Treatment. We may share your health information with health care providers at St. Mary's who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A health care provider at St. Mary's may share your health information with another health care provider inside St. Mary's, or at another health care facility, to determine how to diagnose or treat you. A health care provider may also share your health information with another health care provider to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement for treatment or care we have provided to you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your future treatment or care.

Business Operations. We may use your health information or share it with others in order to conduct our normal business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide to you. We may also share your health information with another company that performs business services for us, such as a billing company. If so, we will have a written contract to ensure that this company also protects the privacy of your health information.

Treatment Alternatives, Benefits and Services. We may use your health information when we contact you in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. We may use your information when deciding whether to contact you or your personal representative to raise money to help us operate. We may also share this information with a charitable foundation that will contact you or your personal representative to raise money on our behalf. If you do not want to be contacted for these fundraising efforts, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**.

2. Friends and Family

We may share your information with friends and family involved in your care, without your written authorization or consent. We will always give you an opportunity to object. We will follow your wishes unless we are required by law to do otherwise.

Friends and Family Involved in Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the St. Mary's, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons. If you object to sharing your information with your family members, personal representative, or other person responsible for your care, please contact **Martha Pellicano, Privacy Officer (718) 281-8587**.

3. Emergencies or Public Need

We may use your health information, and share it with others, in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your written authorization, consent or any other type of permission before using or disclosing your information for these reasons.

Emergencies. We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

Communication Barriers. We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

As Required by Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so.

Victims of Abuse, Neglect or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair and Recall. We may disclose your health information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property;

To Avert a Serious Threat to Health or Safety. We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Inmates and Correctional Institutions. If you later become incarcerated at a correctional institution or detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your authorization if we obtain approval through a special process to ensure that research without your authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right to Inspect and Obtain a Copy of Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request to **Martha Pellicano, Privacy Officer (718) 281-8587**. Upon your request, we will provide you with a copy of your record in the format you request, if it is available. This includes a paper copy or electronic copy of your record, if it is available. If you request a copy of your record, we may charge a fee for the cost of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page for paper and $10.00 for an electronic copy. The fee must generally be paid before or at the time we give the copies to you. For St. Mary's Hospital for Children residents, we will respond to your request for inspection of records within twenty-four hours and we ordinarily will respond to requests for copies within two working days. For patients and clients of all other St. Mary's programs, access to your records will be made within ten days of your request.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy. You may be charged a fee for the cost of preparing the summary of your record.

2. Right to Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please contact **Martha Pellicano, Privacy Officer (718) 281-8587**. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.
If we deny part or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. Right to an Accounting of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which is a list with information about how we have shared your information with others. An accounting list, however, will not include:

- Disclosures we made to you;
- Disclosures we made in order to provide you with treatment or care, obtain payment for that treatment or care, or conduct our normal business operations;
- Disclosures made to your friends and family involved in your care;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers; or
- Disclosures made before April 14, 2003.

To request this list, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**. Your request must state a time period for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to one list within every twelve-month period for free. However, we may charge you for the cost of providing any additional lists in that same twelve-month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting list within 60 days. If we need additional time to prepare the accounting list you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting list. In rare cases, we may have to delay providing you with the accounting list without notifying you because a law enforcement official or government agency has asked us to do so.

4. Right to be Notified in the Event of a Breach.

We will notify you if your medical information has been "breached" which means that the privacy or security of your information has been compromised (used or shared in a way that violates the law).

5. Right to Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to provide you with treatment or care, collect payment for that treatment or care, or to conduct St. Mary's normal business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. If you pay for services or health care items out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We may agree unless a law requires us to share that information.

To request restrictions, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

6. **Right to Request Confidential Communications**

You have the right to request that we communicate with you or your personal representative about your medical matters in a more confidential way. To request more confidential communications, please contact **Martha Pellicano, Privacy Officer at (718) 281-8587**. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how you or your personal representative wishes to be contacted, and how payment for your health care will be handled if we communicate with your personal representative through this alternative method or location.

FOR FURTHER INFORMATION, PLEASE CONTACT:
MARTHA PELLICANO, PRIVACY OFFICER
5 DAKOTA DRIVE, SUITE 200
NEW HYDE PARK, NY 11042
(718) 281-8587

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

PATIENT NAME: ______________________________ Date of Birth: ___________________

I have received this NOTICE OF PRIVACY PRACTICES for St. Mary's Healthcare System for Children. I understand that if I have any questions, I may contact Martha Pellicano, the St. Mary's Privacy Officer, by telephone at (718) 281-8587 or by mail at St. Mary's Healthcare System for Children, Inc., 5 Dakota Drive, Suite 200, New Hyde Park, NY 11042.

Signature ____ Date __________________

Print Name ____

NOTE: Signed acknowledgement by a patient caretaker to be maintained in patient clinical record at St. Mary's Healthcare System for Children.

stmary's
Healthcare System for Children

THE CINDY AND TOD JOHNSON
CENTER FOR PEDIATRIC FEEDING DISORDERS

LETTER OF MEDICAL NECESSITY

Date:
RE:
DOB:

To Dr.

The above patient is awaiting an appointment for a clinic evaluation at the Center for Pediatric Feeding Disorders. In order for us to contact insurance to obtain coverage, we are in need of a Letter of Medical Necessity from the patient's physician. Below is an example of what should be mentioned in the letter. Please fax the Letter of Medical Necessity to Lisa Doyle, Managed Care Liaison at 718-281-8505.

Please include in your letter the following information.

- Patient Name:
- Diagnosis: (with DX codes)
    - Stating any underlying medical conditions and medical issues due to feeding.
- Brief statement about how severity of problem and/or failure to make sufficient gains with other interventions (medical treatments, outpatient or school-based feeding therapy, etc.) warrants more intensive treatment.
- Medical History
- Recent Height, Weight, BMI
- Referral for intensive feeding services at the Center for Pediatric Feeding Disorders

Sincerely,

Lisa J. Doyle

Lisa J. Doyle
Contracting and Payor Relations Specialist
Center for Pediatric Feeding Disorders
29-01 216th Street
Bayside, NY 11360
Tel: 718-819-2749
Fax: 718-281-8505

EVALUATIONS AND SERVICES

CLINIC (Initial Evaluation visit)

Preparing for the visit

- The average wait time from date of referral to initial assessment can take a few weeks.
- All relevant reports and documents including the child's growth chart have to be on file before an evaluation can be scheduled.
- The 3 day food diary should have been sent to the team or presented on the day of the evaluation.

Fees and Payment

- The Managed Care department will process insurance for authorization and detail any charges to the family prior to the evaluation. These charges are based on your child's needs and the level of evaluation service to be conducted.
- Payment is expected on the day of the evaluation. It can be made in check, money order or credit card.

What to Bring

- Families should bring to clinic 2-3 foods the child will consume (preferred) and 2-3 foods the child can but does not consume (non-preferred). These items will be used for the feeding observation portion of the evaluation.
- Families are expected to bring with them all necessary foods (variety, texture), utensils (specialized spoons and oral motor tools) and equipment (special seats, etc.) and reinforcers (toys, videos, IPad).
- Families are encouraged to bring items that will engage their child and occupy their child's attention during that waiting period.
- If you are bringing children who are not part of the evaluation and/or your child requires a level of supervision that will prevent you from interviewing with team members, please attend the appointment with another adult who can assist in supervision.

The Day of the Appointment

- Free parking is available on premises. Please note however that parking spaces are limited; you may need to park on the streets.
- The evaluation can take up to 2-3 hours. You will be kept informed about any unforeseen delays and every effort will be made to provide you with service in a timely way.
- A comprehensive evaluation will be conducted by St. Mary's interdisciplinary team
- Your child will be weighed and height will be taken during the clinic evaluation.
- One or more specialists from Nutrition, Gastroenterology, Nursing, Psychology and Speech/Feeding may join in the evaluation at different periods of the evaluation.
  Team members may include;
    - Dr. Edwin Simpser- Gastroenterologist, CEO
    - Dr. Stephanie Lee – Behavioral Psychologist
    - JoKathleen Rodriguez- Pediatric Nurse Practitioner
    - Anselma Kuljanic- Registered Dietitian
    - Elise Jusko- Speech Language Pathologist
    - Stella Yusupova- Speech Language Pathologist, Director

- Besides a detailed interview and document review, observation of a feeding session will also be conducted. Caregivers will feed the child as they would at home and specialists will document observations in order to provide you with specific feedback and treatment options.
- An oral motor assessment will be conducted and clinician probe with non-preferred foods may be implemented if warranted.

- After conducting the evaluation, the interdisciplinary team members will meet by themselves to discuss the findings and develop appropriate recommendations for the child and family. Following that meeting, one or more of the team members will meet with the family to explain the findings and recommendations.

After the Appointment

- A written report with findings and recommendations will follow in approximately 2 weeks from the date of the evaluation. Where indicated, community providers will be contacted for consultation on recommended changes to the child's feeding status.
- There is currently a short wait list for Day Patient Program admission. However, there will be times when an opening may come sooner than expected. At that time an offer will be made to families to take up the available slot. If a family is unable to accept the offer the child will be put back on the waiting list.
- Following clinic evaluation St. Mary's staff will consult with your current doctors (if necessary) and feeding therapists.
- While you are on wait list and during your admission we will consult with your current GI/Pediatrician. Decisions concerning admission (timing, tube feeds, supplements, medications, etc.) will be made with their input.
- Caregivers and community providers are expected to continue to work on the child's feeding difficulties while waiting on the child's admission. In addition, medical tests and changes to the child's feeding regimen may be recommended to assure that the child is ready to benefit from the program. Failure to complete these recommendations may delay the child's admission. It is the family/caregiver's responsibility to contact relevant program staff with updates on recommendations and/or obstacles to following recommendations. This should be a collaborative process between caregivers and the evaluation team.

Follow up clinics (while waiting for admission to the Day Patient Program)

- The schedule for follow up clinics is based on each child's needs. The clinic team will arrange follow up appointments as needed. Our recommendations and admission guidelines may change based on our findings during follow-up evaluations.
- Only specialists deemed essential will see the child during the follow up visits. Caregivers may request to meet with other specialists if they need additional consultation. Caregivers are encouraged to make such requests through our Program Coordinator in advance of the clinic appointment.
- Follow up evaluations will last approximately 1 hour. Updates on the child's progress and any new concerns will be addressed. A feeding observation will be conducted. Caregivers need to bring with them all necessary food, utensils, equipment and reinforcers used during meal times.
- Caregivers should also bring with them tests/reports obtained since the last clinic visit. A written report will follow in approximately 2 weeks.

The Day Patient Program

Treatment

- The capacity of the Day Patient Program is a census of six patients. The program operates five days a week, Monday - Friday, from 8AM-4:00PM.
- Cindy & Tod Johnson Center for Pediatric Feeding Disorders does not provide transportation services. However, families who qualify for ACCESS-A- RIDE will be referred/given a letter and if a family has transportation benefits through their insurance, we will assist in setting up the pick-up/ drop off times. It is the responsibility of the caregivers to request consideration for assistance.

- The Day Patient Program currently has contracts with certain insurance carriers. Insurance carrier is notified, by the Program Coordinator, of the planned admission at least 30 days prior to admission. Pre-certification/authorization of services will be initiated. Letters of Medical Necessity, program goals, treatment plan, referrals and a sample schedule will be included in the request for authorization. Caregivers are responsible for obtaining all referrals required by their insurance carrier and for requesting letters of medical necessity from their community medical providers (Pediatricians, GI specialists, etc.).
- When appropriate, we will assist you in appealing all insurance denials. Should the appeal fail, the family will be responsible for the charges. A written agreement will be drawn up for all payment plans.
- During the Day Patient admission (approximately 4 - 6 weeks) a child may receive up to 4 feeding sessions daily (this is based on the child's need). There are 2 daily feeding schedules. The first schedule option starts at 8:15am, 9:45am, 11:15am, and 1:30pm. The second schedule starts at 9:00am, 10:30am, 12:45pm, and 2:15pm. Patients are slotted into available schedules. Patients who are unable to accept the available schedule will be put back on the waiting list.
- The standard therapeutic session is up to 45 minutes in length. However, meal duration may vary in length depending upon the child's status. Oral motor exercises and sensory modulation therapy may be conducted prior to commencing the therapeutic meal based on the child's need.
- A feeding therapist will be assigned to each child. The Feeding therapist is responsible for coordinating care and services for the child during the admission including intervention plans, team meetings, documentation, and communication with other team members and community providers.
- There will be other therapists assigned to treat your child during admission and a supervisor will oversee your child's treatment during admission. Therapists are assigned to teams based on their availability and their specific skills deemed essential to a particular child. All of our therapists are trained in the protocols and service needs of each child.
- The Feeding Team at St. Mary's will be in close contact with the child's GI and/or Pediatrician throughout their admission and all major decisions concerning medications, formulas, supplements, etc. will be discussed with those doctors. The feeding team may also consult with the child's other community providers, and keep them abreast of the child's progress in the feeding program.
- The Administrator of The Feeding Program is Dr. Simpser who is also the President and the Chief Executive Officer of the hospital. Dr. Simpser evaluates children at their initial evaluation in clinic but does not have direct contact with them during their Day Patient admission. Dr. Simpser is updated on the progress of all Day Patients weekly by program nurse practitioner. Any medical/GI concerns that caregivers have will be discussed first with nurse practitioner and she will then consult with Dr. Simpser.
- All Day Patients will remain in the care of their Pediatricians and GI doctors during their admission and following discharge.

Free Time During the Day

- Caregivers are expected to attend to their children between therapy sessions.
- Caregivers have access to designated waiting areas within the hospital, as well as playground.
- Caregivers will have accessibility to a locker to store personal belongings/coats; families must provide their own lock.
- Families and patients are free to leave the hospital grounds between therapy sessions. However, they have to return on time for the therapy sessions.
- At times there are formal play groups available for children during their breaks.
- There is a cafeteria where families can purchase food for themselves. Breakfast is served from 8:30am-10am; Lunch is served from 11:30am-2pm.

What to Expect During the Day Patient Admission

Assessment and Goal Setting

- Assessments will be conducted in feeding, oral-motor, behavior management, and reinforcers during the first few days of admission. Feeding assessments will include parent fed sessions and therapist(s) fed sessions.
- A goal setting meeting will be held after completion of the assessments. The interdisciplinary feeding team will meet with the child's caregivers to discuss assessment findings and mutually develop goals for the admission.
- Children can be expected to have difficulty adjusting to the initial stages of treatment due to changes in their feeding structure, schedules, feeders, and the procedures used to help them improve their feeding. In general, children may show increased anxiety, crying, and food refusal. However, it has been our experience that the children will, in most cases, adjust after a few days and be less stressed.

Parent Participation and Training

- Caregivers may be asked to watch their children's feeding sessions through a television monitor from the observation room during the initial stages of treatment. This is dependent upon factors such as: the type of intervention used, ability to separate, etc. Therapists will meet families after each session and discuss the treatment session and answer caregiver questions.
- Caregivers will be systematically faded into the feeding sessions based on the changes exhibited by the child. Eventually, the parent will be feeding the child with the therapist watching the session through the television monitor.
- Caregivers are trained to a minimum of 85% accuracy in implementing the child's treatment protocol.
- Caregivers will maintain their pre-admission feeding regimen at home until requested by the team to make changes at home. These changes will be recommended based on the child's progress in the program.
- Caregivers are responsible for collecting data on home fed meals. This data is very important as it allows the feeding team to adjust treatment protocols appropriately.
- It is critical that the caregivers implement the protocol consistently and accurately. Caregivers should not make changes to the protocol without prior discussion with the primary therapist.
- The primary therapist will work with the caregivers to systematically fade out the treatment until the child can feed without the protocol.

General

- Children are typically weighed upon admission and once a week throughout admission.
- Family meetings are held on Fridays of each week during program hours. The goal of the meeting between the caregivers and the feeding team is to discuss the status of their child's feeding goals and progress. The team will also explain to the caregivers the program goals and treatment for the following week. More importantly, this meeting is for the caregivers to express their feelings and concerns and to get their questions answered. The caregivers will also be given a written report upon discharge.
- Caregivers may be asked to fill out home data sheets. Data sheets include date, time, type and amount of food consumed, including any behaviors the child exhibited during the meal. Additional information may be requested on an individual basis.
- Nutritionist will make recommendations in collaboration with the nurse practitioner and your outside doctors to help your child improve nutritional status and meet goals.
- Manipulation of times/rate of tube feeds or change in formula may be necessary to help your child reach feeding program goals.
- Your child should attend the program daily to benefit from the treatment. Caregivers should be committed to the program and clear all barriers before the child's admission to ensure they can attend

the program daily. One unexcused absences could result in the child being discharged from the program. The child can be readmitted into the program at a later date when the caregivers are ready to attend the program regularly and follow the recommendations.
- Absences due to illness require a doctor's note.
- Children having a fever will be examined by the nurse and if necessary asked to return home. Children must be fever-free without medication for at least 24 hours before returning to the program.

Discharge Planning
- It is essential that all persons feeding the child at home/school, etc. are identified early in the admission to the program so they can be trained in the protocol.
- Discharge planning will be conducted with the caregivers. A discharge packet containing the written protocols, data sheets, nutritional guidelines/meal plan, medical instructions, and DVD recording of the meal will be given to the caregivers.
- It is essential that the caregivers work with the team to make all arrangements at home to implement the protocol upon discharge. These arrangements including feeders, resources, schedules, etc. should be completed prior to the child's discharge from the program.
- Patients will be discharged following a very specific feeding protocol. It will be expected that caregivers feed their children following that protocol and on the schedule that has been determined prior to discharge by the primary therapist, caregiver and nutritionist. Any potential obstacles/concerns about implementing the protocol accurately should be discussed as soon as they arise so that solutions can be developed. Failure to follow established protocols after discharge could lead to regression of skills gained during treatment.
- Caregivers are encouraged to begin arranging feeding therapy prior to discharge from The Day Patient program. The Feeding Team will do whatever they can to help the parent secure continued feeding therapy (i.e., referral). The Feeding Program does not guarantee a feeding therapist that is trained to continue services upon discharge.
- It is encouraged that the therapists who will be working with the child post-discharge spend a day with the child's primary therapist to be trained in the feeding protocol.
- Each family is encouraged to have 2 people participate in the Day Patient program so that there are 2 trained "feeders" at the time of discharge.

Post- Discharge
- In most cases children are scheduled for 2 follow up visits within 6 weeks from discharge. The follow up date and times are to be arranged between primary therapist and a caregiver.
- Caregivers are to bring all food and necessary equipment/tools for the child's follow up visits. Caregivers will feed the child during follow up visit, while the therapist observes and provides feedback.
- Upon the last follow up visit with the primary therapist, a Post-Discharge Clinic will be set if necessary to further assess the child's long term feeding goals and the necessity to return for a possible second admission.
- The Managed Care department will seek reimbursement authorization from insurance for Post-Discharge clinic. Caregivers will be responsible for payments if insurance denies payment. This payment is expected at time of appointment and payment methods accepted include cash, credit, and check. The program will provide you with a medical bill and receipt of payment.
- Eligible candidates will be placed on the waiting list for a 2nd admission to address further goals upon child's readiness (i.e., chewing).
- Program Satisfaction Surveys should be completed and returned upon discharge as soon as possible.

PLEASE DO NOT HESITATE TO ASK IF YOU HAVE QUESTIONS AND/OR CONCERNS REGARDING ANY OF THE INFORMATION CONTAINED IN THIS PACKET