



Dear Parent/Guardian,

Thank you for your interest in the medical Pediatric Day Healthcare Program (PDHC) at St. Mary's Hospital for Children. St. Mary's PDHC Program offers therapeutic and medical after-school, weekend, and summer programs for children 6-18 years of age and young adults from 18-25 years of age who have cognitive and/or physical disabilities.

Before an intake meeting can be scheduled, the following forms need to be completed and returned to our office. Once the documents are reviewed by our team, you will be called for an appointment to discuss your child's participation in our program. These forms include:

- Health Examination Form/Full Medical Evaluation
- Updated vaccination record including an updated PPD within the past 6 months.
- Medical Orders (attached) completed by your child's physician (Please include an order for Benadryl PRN if the child has allergies and an order for Tylenol PRN for pain or fever)
- Copy of the Medicaid Card and/or your commercial insurance card
- Individualized Education Plan (IEP) (if applicable)
- Psychological Evaluation (if available)

If you need any assistance with this application process or wish to setup an appointment to tour the program, please contact me at 718-281-8961.

Sincerely,

Allison McGeough

Allison McGeough
Manager
PDHC Department

ST. MARY'S PEDIATRIC DAY HEALTHCARE PROGRAM
29-01 216th Street Bayside New York 11360
718-281-3991



Estimado Pariente/Guardian:

Gracias por su interés en el Programa Medico Extraescolar de St. Mary's Hospital for Children (PDHC). El Programa de PDHC ofrece programas terapéutico y medico después de la escuela, en los fines de semana y programas medico de verano para niños entre 6 y 18 años de edad y los adultos jóvenes de 18-25 años de edad que tengan discapacidades cognitivo o físico.

Aquí está la lista de las formas necesarias que deben ser completadas y regresada a nuestra oficina antes que podamos darle una cita para hablar sobre la participación de su niño en nuestro programa. Estas formas incluyen:

- Evaluación Médica/Examen de salud física
- Lista de vacunaciones corriente
- Ordenes Médicas (unida aquí); si su niño tiene alergias o toma aspirina para dolor o fiebre, se necesita una orden medica
- Copia de su tarjeta de Medicaid o seguro comercial
- El Plan Individualizado de Educación (IEP) (si aplica)
- Evaluación psicológica (si aplica)

Una vez que todos los documentos estén recibidos por nuestra oficina, nosotros le llamaremos a establecer una cita donde se determine el mejor programa para su niño/adulto joven. Si necesita cualquier ayuda con este proceso de aplicación o desea una cita para viajar el programa, contacta por favor la Supervisora del programa, Allison Carney en 718-281-8961 o a Gloria Reyes en 718-281-3991.

Sinceramente,

Allison McGeough

Allison McGeough
Gerente
Departamento de PDHC

ST. MARY'S PEDIATRIC DAY HEALTHCARE PROGRAM
29-01 216th Street Bayside New York 11360
718-281-3991



ST. MARY'S HEALTHCARE SYSTEM FOR CHILDREN

Pediatric Day Healthcare Program Referral Form

St. Mary's Hospital for Children

29-01 216th Street + Bayside, New York 11360 + Tel: 718-281-3991 + Fax: 718-281-8920

e-mail address: pdhc@stmaryskids.org

- After-School Program (Monday-Friday) 3:00 – 6:30 pm
 Saturday AM (9:00 am-1:00 pm) PM (1:00 am-5:00 pm)
 Sunday AM (10:00 am-3:00pm)
 Young Adult (18-25 yrs old) (9:00 am – 2:00 pm)
 Summer (July-August) AM (9:00 am-1:00 pm) PM (1:00 am-5:00 pm)

Referral Date: _____

Patient's Full Name: _____

A/K/A: _____

Social Security No: _____

Mother's Name: _____

Father's Name: _____

Guardian's Name: _____

Home Address: _____

City: _____, NY Zip: _____

Medicaid #/Insurance Information: _____

Home Phone: _____

Alternate Phone: _____

Cell Phone: _____

Age: _____ Date of Birth: _____

Gender: Female Male

Liaison: _____ Phone: _____

Referring Agency: _____

Referral Source: MD NP RN SW Parent

Additional contact info (MSC, Social Worker, Case Manager, Physician): _____

Services currently receiving:

PT OT Nutrition ST Home Care Other: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Completed by: _____ Relationship: _____ Date: _____

St. Mary's Hospital for Children does not discriminate in the admission, retention, or care of its patients because of race, creed, color, national origin, sex, disability, source of payment or sponsorship, marital status or sexual preference.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____	
Child's Address		Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other		
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____	Phone Numbers Home _____ Cell _____ Work _____
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian Last Name	First Name			
<input type="checkbox"/> Foster Parent					

TO BE COMPLETED BY HEALTH CARE PROVIDER If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent If persistent, check all current medication(s): <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____
<i>Explain all checked items above or on addendum</i>		

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: NI Abnl NI Abnl NI Abnl NI Abnl NI Abnl <input type="checkbox"/> HEENT <input type="checkbox"/> Lymph nodes <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Dental <input type="checkbox"/> Lungs <input type="checkbox"/> Genitourinary <input type="checkbox"/> Neurological <input type="checkbox"/> Language <input type="checkbox"/> Neck <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Extremities <input type="checkbox"/> Back/spine <input type="checkbox"/> Behavioral Describe abnormalities: _____
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS	Tuberculosis <small>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</small>																																
	<table border="1"><thead><tr><th></th><th>Date Done</th><th>Results</th></tr></thead><tbody><tr><td>Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small></td><td>____/____/____</td><td>_____ µg/dL</td></tr><tr><td>Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small></td><td>____/____/____</td><td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td></tr><tr><td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td><td>____/____/____</td><td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td></tr><tr><td>Hemoglobin or Hematocrit (age 9-12 mo)</td><td>____/____/____</td><td>_____ g/dL _____ %</td></tr></tbody></table>		Date Done	Results	Blood Lead Level (BLL) <small>(required at age 1 yr and 2 yrs and for those at risk)</small>	____/____/____	_____ µg/dL	Lead Risk Assessment <small>(annually, age 6 mo-6 yrs)</small>	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %	<table border="1"><thead><tr><th></th><th>Date Done</th><th>Results</th></tr></thead><tbody><tr><td>PPD/Mantoux placed</td><td>____/____/____</td><td>Induration _____ mm</td></tr><tr><td>PPD/Mantoux read</td><td>____/____/____</td><td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td></tr><tr><td>Interferon Test</td><td>____/____/____</td><td><input type="checkbox"/> Neg <input type="checkbox"/> Pos</td></tr><tr><td>Chest x-ray <small>(if PPD or Interferon positive)</small></td><td>____/____/____</td><td><input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl</td></tr><tr><td>Vision <small>(required for new school entrants and children age 4-7 yrs)</small></td><td>____/____/____</td><td>Acuity Right ____/____ Left ____/____ <input type="checkbox"/> with glasses Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes</td></tr></tbody></table>		Date Done	Results	PPD/Mantoux placed	____/____/____	Induration _____ mm	PPD/Mantoux read	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	Interferon Test	____/____/____	<input type="checkbox"/> Neg <input type="checkbox"/> Pos	Chest x-ray <small>(if PPD or Interferon positive)</small>	____/____/____	<input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl	Vision <small>(required for new school entrants and children age 4-7 yrs)</small>	____/____/____
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IMMUNIZATIONS - DATES CIR Number of Child _____	Influenza _____
Hep B _____	MMR _____
Rotavirus _____	Varicella _____
DTP/DTaP/DT _____	Td _____
Hib _____	Tdap _____ Hep A _____
PCV _____	Meningococcal _____
Polio _____	HPV _____
	Other, Specify: _____

RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ _____ _____ ICD-9 Code _____
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Health Care Provider Signature	Date	DOHMH PROVIDER I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____ - _____	State	I.D. NUMBER _____
Fax (____) _____ - _____	Zip	REVIEWER: _____



**ST. MARY'S PEDIATRIC DAY HEALTHCARE PROGRAM
PHYSICIAN MEDICAL ORDERS**

Client: _____ DOB: _____ Height: _____ Weight: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

Prognosis: Good Fair Allergies: _____

Activity Restrictions: No Yes, describe: _____

Has the child ever exhibited exercise induced asthma? No Yes

If yes, please explain how it's treated: _____

Special Instructions: _____

MEDICATIONS: (List all medications the client is taking). Please include any order for PRN Tylenol/Motrin for pain/fever and/or PRN nebulizer treatments, if applicable.

MEDICATION	DOSE	FREQUENCY	ROUTE

NURSING ASSESSMENTS:

Vital Signs, Frequency: _____ Urinary Catheterizations, Frequency: _____

Blood glucose monitoring: Frequency: _____ Tube Feedings GT button/tube care

Central line care Oximeter reading Other: _____

Systems to Focus on: Respiratory Cardiovascular Neurological GI/GU

Other: _____

Diet: Regular Portion Control Carb counting _____ carbs per meal

Other: _____

Physical Therapy: N/A As per therapist's evaluation

Occupational Therapy: N/A As per therapist's evaluation

Speech Therapy: N/A As per therapist's evaluation

Nutrition: N/A As per evaluation or nutritional risk screen

Other: Weight Management; Respiratory Illness; Diabetes Management

If the child/young adult is a diabetic, please complete the reverse side of this form.

Physician/NP Name: (Print) _____

Signature: _____ License # _____

Phone: _____ Fax: _____ Date: _____



Please provide the following baseline data for our files:

1. HgbA₁C results: _____ Date: _____
2. Microalbumin urea: _____ Date: _____
3. Attach a copy of the patient's most recent lipid profile.

PHYSICIAN ORDERS FOR DIABETICS

Pre-Breakfast	Pre-Lunch	Pre Dinner
Target BG: _____	Target BG: _____	Target BG: _____
Correction Factor: _____	Correction Factor: _____	Correction Factor: _____
Insulin Name _____	Insulin Name _____	Insulin Name _____
Sliding Scale: For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____	Sliding Scale: For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____	Sliding Scale: For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____ For BG ____, give ____

Physician Orders Valid for 30 days.

Physician's Name (Print) _____

Physician's Signature: _____

Date: _____