Dear Parent/Guardian,

Thank you for your interest in the Medical 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 18-30 years of age who have cognitive and/or physical disabilities. PDHC is not a program for recreation.

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. No meeting will be scheduled if all the forms are not submitted. 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
Director
PDHC Department
Medical Day Care Referral Form

Referral Date: ____________________  

Client information:

Name: ____________________________  
Medicaid Number: __________________

Address: ____________________________  
Social Security number: __________________

Date of Birth: ______________________  
Age/gender: __________________________

Primary Diagnosis: __________________

Parent/Guardian Information:

Name: ____________________________  
Email address: _______________________

Address: ____________________________  
Cell Number: _________________________

Home number: ________________________

Referring Physician contact information:

Name: ____________________________  Phone number: ___________________________  Email: ___________________________

Service coordinator/MSC:

Name: ____________________________  Phone number: ___________________________  Email: ___________________________

Services currently receiving (please circle)?

PT  OT  ST  Home Care  N/A

If yes, contact information for agency: ___________________________

Program interested in (please circle):

Young Adult (9a – 2p)  After school (3p – 6:30pm)  Saturday (10a – 3p)  Sunday (10a – 3p)

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.

St. Mary's Pediatric Day Healthcare Program  
At St. Mary's Hospital for Children  
29-01 216th Street | Bayside, NY 11360 | 718-281-8961  
www.stmaryskids.org
ST. MARY’S PEDIATRIC DAY HEALTHCARE PROGRAM
PHYSICIAN MEDICAL ORDERS

Client: ___________________________ DOB: _______ Height: _____ Weight: ______

Primary Diagnosis (include ICD-10 code): __________________________
Secondary Diagnoses (Include ICD-10 code): __________________________

Prognosis: □ Good  □ Fair  □ Allergies: __________________________

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.

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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

□ I certify that the above patient does not require 24 inpatient or residential health care and is
medically appropriate for participation in the Medical Day Care Program.

□ I certify that the above patient is not suffering from a communicable disease that constitutes
a danger to other clients or staff.

Physician Name: (Print) ___________________________
Signature: ___________________________ License #: __________________
Phone: ___________________________ Fax: ___________________________ Date: __________

THIS FORM MUST BE STAMPED BY THE PHYSICIAN
If the child/young adult is a diabetic, please complete the reverse side of this form.

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# Child & Adolescent Health Examination Form

**NYC Department of Health & Mental Hygiene — Department of Education**

**Student ID Number:**

**Child's Last Name**

**First Name**

**Middle Name**

**Sex**

**Female**

**Male**

**Date of Birth:**

**City/Borough**

**State**

**Zip Code**

**School/Center/Camp Name**

**District**

**Phone Numbers**

**Health Insurance:**

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<th>Yes</th>
<th>No</th>
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**Parent/Guardian Last Name**

**First Name**

**Cell**

**Work**

## To Be Completed by Healthcare Provider

If "yes" to any item, please explain (attach addendum, if needed).

### Birth History (age 0-6 yrs)

- [ ] Uncomplicated
- [ ] Preterm: ______ weeks gestation

### Complications

- [ ] Birth asphyxia
- [ ] Pneumonia
- [ ] Other ______

### Allergies

- [ ] Pfizer
- [ ] Epi pen prescribed
- [ ] Other ______

### Medications

- [ ] None
- [ ] Yes (list below)

### Dietary Restrictions

- [ ] None
- [ ] Yes (list below)

## Physical Examination

### General Appearance

- [ ] HIV
- [ ] HEENT
- [ ] Lymph nodes
- [ ] Abdomen
- [ ] Skin
- [ ] Neuromuscular
- [ ] Ophthalmic
- [ ] Nutritional
- [ ] Cardiac/Vascular
- [ ] Extremities
- [ ] Back/spine
- [ ] Behavioral

### Describe abnormalities:

## Hemoglobin or Hematocrit (age 8-12 yrs)

- [ ] Hgb
- [ ] Hct

## Screening Tests

### Blood Lead Level (BLL)

- [ ] At or below 10 µg/dL
- [ ] At or above 10 µg/dL

### Lead Risk Assessment

- [ ] At risk as 0-1 µg/dL
- [ ] Not at risk

### Hearing

- [ ] Pure tone audiometry
- [ ] OAE

### Immunosuppression (age 2-5 yrs)

- [ ] Head Start Only

## Immunizations

- [ ] Hep B
- [ ] Haemophilus
- [ ] DTP/DTaP
- [ ] Hib
- [ ] PCV
- [ ] Polio

## Recommendations

- [ ] Full physical activity
- [ ] Full diet

## Assessment

- [ ] Well Child (Vaccinated)
- [ ] Diagnoses/Problems (Yes)

## ICD-9 Code

### Provider Information

**Provider Name and Degree**

**Provider License No. and State**

**Facility Name**

**National Provider Identifier (NPI)**

**Address**

**City**

**State**

**Zip Code**

**Telephone**

**Fax**

## Certificate of Competency

**Date**

**Provider**

**ICD-9 Code**

**Provider Type**

**Provider License No. and State**

**Facility Name**

**National Provider Identifier (NPI)**

**Address**

**City**

**State**

**Zip Code**

**Telephone**

**Fax**

## reviewer

**Date**

**ICD-9 Code**

**Provider Type**

**Provider License No. and State**

**Facility Name**

**National Provider Identifier (NPI)**

**Address**

**City**

**State**

**Zip Code**

**Telephone**

**Fax**