stmaryskids

Where big hearts
help little patients

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

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Medical Day Care Referral Form

Referral Date: _____

Client information:

Name: _____ Medicaid Number _____

Address: _____ Social Security number _____

_____ Age/gender _____

Date of Birth: _____ 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 Pediatric Day Healthcare Program
At St. Mary's Hospital for Children
29-01 216th Street | Bayside, NY 11360 | 718-281-8961
www.stmaryskids.org

stmary'skids

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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.**

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

☐ **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

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) __/__/____

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers: Home, Cell, Work

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

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

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ cm (___ %ile)

Weight _____ kg (___ %ile)

BMI _____ kg/m² (___ %ile)

Head Circumference *(age ≤2 yrs)* _____ cm (___ %ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__	_____ µg/dL
	__/__/__	_____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit *(age 9-12 mo)*	__/__/__	_____ g/dL _____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration _____mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4-7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B __/__/____ __/__/____ __/__/____ __/__/____

Rotavirus __/__/____ __/__/____ __/__/____

DTP/DTaP/DT __/__/____ __/__/____ __/__/____

__/__/____ __/__/____ __/__/____

Hib __/__/____ __/__/____ __/__/____ __/__/____

PCV __/__/____ __/__/____ __/__/____ __/__/____

Polio __/__/____ __/__/____ __/__/____ __/__/____

Influenza __/__/____ __/__/____ __/__/____ __/__/____

MMR __/__/____ __/__/____ __/__/____

Varicella __/__/____ __/__/____

Td __/__/____ __/__/____ __/__/____

Tdap __/__/____ Hep A __/__/____ __/__/____

Meningococcal __/__/____ __/__/____

HPV __/__/____ __/__/____ __/__/____

Other, *Specify:* _____ __/__/____; _____ __/__/____

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __/__/____

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* ICD-9 Code

_____ ____

_____ ____

_____ ____

Health Care Provider Signature | Date __/__/____

DOHMH ONLY PROVIDER I.D.

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/____ I.D. NUMBER

REVIEWER:

Copies: White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian