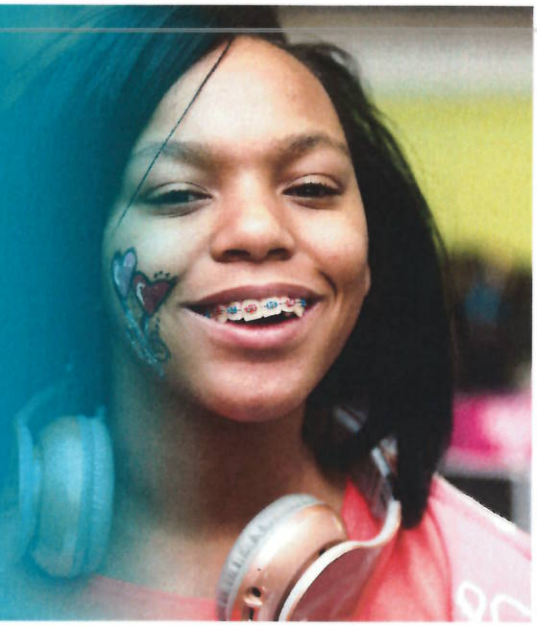
Medical Day Healthcare Program



Therapeutic After School, Young Adult and Weekend Program

Program Highlights

- Nursing care
- Rehabilitative services
- Daily hot meals
- Nutritional counseling
- Healthy cooking groups
- Indoor/outdoor sports and play
- Transportation to/from program
- Academic support and homework assistance
- Community integration
- Independence with ADL skills
- Socialization & confidence building

St. Mary's Healthcare System for Children, a national leader in pediatric post-acute care, offers dynamic after-school, weekend, and summer camp programs for children ages 5-18 years and young adults from 18-30 years of age who have medical, physical, and developmental disabilities. Located on the park-like grounds of St. Mary's flagship facility in Bayside, NY, St. Mary's Medical Day Healthcare Program provides therapeutic, rehabilitative, and recreational activities to help children and young adults with special healthcare needs reach their full potential.

Children receive state-of-the-art rehabilitative and medical care while participating in a variety of supervised indoor and outdoor play, sports, arts & crafts, and other fun therapeutic recreation and social activities. The program also includes on-site homework assistance, a hot meal, and round-trip transportation.

The Young Adult program includes a focus on vocational skills. St. Mary's counselors work with participants to promote their skills, confidence, and independence in a nurturing and fun environment. Family members are also educated on the critical roles they play in the child's success.

Eligibility

The program is open to children 5-18 years of age and young adults from 18-30 years of age who have a medical diagnosis and a physical and/or developmental delay. The child must be eligible for Medicaid or Managed Medicaid and require medical services or therapy and not receive those services in the home or through another agency.

For more information or to request a phone interview to verify a child's eligibility, please contact St. Mary's Medical Day Healthcare Program at 718-281-8729.

29-01 216th Street
Bayside, NY 11360
www.stmaryskids.org

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Dear Parent/Guardian,

Thank you for your interest in the Medical Day Healthcare Program (MDHC) at St. Mary's Hospital for Children. The MDHC Program is a medical model program that consists of a young adult, after-school and Saturday program for participants who have cognitive/physical disabilities.

In order for an intake to be scheduled, the following documents are needed to be completed and returned to our office. Once the team reviews the documents, the parent/guardian will be contacted to schedule the evaluation for the participant. The meeting will not be scheduled if all the forms are not submitted and fully completed. The documents needed are:

- Health Examination Form/Full Medical Evaluation
- Updated vaccination record including an updated PPD within the last 6 months.
- Medical Order form (attached) completed by your child's physician
  (Please have your doctor include a PRN order for Benadryl if your child has allergies and a PRN order for Tylenol for pain or fever)
- Copy of Medicaid Card and commercial insurance card
- Social Security Card
- Individualized Education Plan
- Life Plan
- Psychological Evaluation

Once your referral documents are completed, they can be emailed to pdhc@stmaryskids.org, faxed to 718-281-8920, or sent via mail ATT: MDHC Program. If you need any assistance with this application process, please feel free to contact our coordinator at 718-281-8729.

Sincerely,

Tiffany Damers

Tiffany Damers
Director
Rehabilitation Services

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Medical Day Healthcare Referral Form

Referral Date:_____

Participant Information:

Name:_____Date of Birth/Age:_____

Address:_____

Medicaid Number:_____ Social Security Number:_____

Gender:_____ Primary Diagnosis:_____

Parent/Guardian Information:

Name(s):_____

Address:_____

Cell:_____Home:_____

Email address:_____ Preferred Language:_____

Physician Contact Information:

Name:_____Phone:_____Email:_____

Case Managers Information:

Name:_____Phone:_____Email:_____

Services the participant is receiving

Physical Therapy	☐ at school	☐ homecare	☐ outpatient
Occupational Therapy	☐ at school	☐ homecare	☐ outpatient
Speech therapy	☐ at school	☐ homecare	☐ outpatient

Program Interested in:

☐ Young Adult (9a-2p) ☐ Afterschool (3p-6:15p) ☐ Saturday (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 Medical Day Healthcare Program
At St. Mary's Hospital for Children
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CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE 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 | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs)

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs (list) _____

☐ Foods (list) _____

☐ Other (list) _____

Attach MAF if in-school medications needed

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

☐ Asthma (check severity and attach MAF): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status: ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ 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)
☐ Hospitalization
☐ Surgery
☐ Other (specify) _____

Explain all checked items above. ☐ ***Addendum attached.***

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below)

PHYSICAL EXAM Date of Exam: ___/___/___

Height _____ cm (____ %ile)

Weight _____ kg (____ %ile)

BMI _____ kg/m² (____ %ile)

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

Blood Pressure (age ≥3 yrs) _____ / _____

General Appearance: ☐ Physical Exam WNL

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

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs)

Validated Screening Tool Used? ☐ Yes ☐ No — Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: _____

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes (list below)

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
Child Care Only		
Hemoglobin or Hematocrit	___/___/___	_____ g/dL _____ %

Hearing

	Date Done	Results
< 4 years: gross hearing	___/___/___	☐NI ☐Abnl ☐Referred
OAE	___/___/___	☐NI ☐Abnl ☐Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐NI ☐Abnl ☐Referred

Vision

	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ NI ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral (pain, swelling, infection)	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number _____ Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

Report only positive immunity:

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	___/___/___

Report only positive immunity: IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ Well Child (Z00.129) ☐ Diagnoses/Problems (list) — ICD-10 Code

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (specify) _____

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

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other _____

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY PRACTITIONER I.D.

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

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone | Fax | Email

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

Comments:

Date Reviewed: ___/___/___ I.D. NUMBER

REVIEWER:

FORM ID#

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

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

Primary Diagnosis (include ICD-10 code): _____

Secondary Diagnoses (include ICD-10 code): _____

Allergies: _____

Has the child ever exhibited exercise induced asthma? ☐ No ☐ Yes- If yes, please explain how it's treated: _____

MEDICATIONS: (List all medications the client is taking). PLEASE INCLUDE ORDERS FOR PRN TYLENOL/MOTRIN/BENEDRYL FOR PAIN/FEVER/ALLERGIES.

FREQUENCY	MEDICATION			

NURSING ASSESSMENTS:

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

☐ Blood glucose monitoring: Frequency: _____ ☐ Tube Feedings (provide specific medical orders)

☐ Central line care ☐ Oximeter reading ☐ Trach Care (provide specific medical orders)

Systems to Focus on: ☐ Respiratory ☐ Cardiovascular ☐ Neurological ☐ GI/GU

☐ Other: _____

Diet: ☐ Regular ☐ Modified ☐ Carb counting _____carbs per meal

☐ Other: _____

Physical Therapy: ☐ as per therapist evaluation

Occupational Therapy: ☐ as per therapist evaluation

Speech Therapy: ☐ as per therapist evaluation

Nutrition: ☐ as per therapist evaluation

☐ **I certify that the above patient does not require 24hr 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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