bethany children's
HEALTH CENTER

Post-Operative Admission Packet

PATIENT INFORMATION

Please print. Fill in all blanks.

PATIENT - First Name	Middle Initial	Last Name	Father's Name
Date of Birth	Gender	Social Security #	Mother's Name

REFERRING DOCTOR or FAMILY PHYSICIAN – Name		Ref. Dr.'s Phone # (with area code)	Ref. Dr.'s Fax # (with area code)
Referring Doctor's Address	City	State	Zip Code

CUSTODIAL PARENT/GUARDIAN – Name (if different from above)			Relationship to Patient	
Address	City	State	Zip Code	County
Employer	Home phone (with area code)	Work phone (with area code)	Cell phone (with area code)	

NEXT OF KIN – Name		Relationship to Patient	
Address	City	State	Zip Code
Employer	Work phone (with area code)	Home phone (with area code)	Cell phone (with area code)

MEDICAID OR DDSD FUNDING

Medicaid Number	Case Manager	Phone Number

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY – Name	Insured's Name		Insured's Date of Birth	Insured's SS#
Case Manager	Phone Number			
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address	City		State	Zip Code

SECONDARY INSURANCE COMPANY – Name	Insured's Name		Insured's Date of Birth	Insured's SS#
Customer Service/Elig. & Benefits Phone #	I.D. #	Group #	Insured's Employer	Relationship to Patient
Claims Address	City		State	Zip Code

SURGERY INFORMATION -

Name of physician performing the surgery: _____

Surgical procedure being performed: _____

_____

Name of hospital where surgery is being done/Date surgery being done: _____

_____

Anticipated date of admission to The Children's Center Rehab Hospital and anticipated length of stay: _____

_____

Post-surgical precautions and duration of precautions: (ex. Weight bearing restrictions) _____

Post-surgical casts/braces and duration of treatment: _____

Current diet: _____ Formula: _____ Volume: _____

Times: _____ Additional water: _____ Modifiers (Benefiber, etc.): _____

Current height: _____ Weight: _____

Current medications-please bring you child's current medications at the time of admission:

Medication	Dose	Route	Time given/frequency
(ex:) Keppra	5 mg	Gtube	8 am and 8 pm

Home pharmacy: Name _____ Phone number _____

Major illnesses and hospitalizations: _____

Past surgeries with dates: (orthopedic, ENT, etc.)_____

Allergies: _____

EDUCATION – ATTACH COPY OF CURRENT IEP (Individual Education Plan)

Is your child currently attending school? ☐ Yes ☐ No

If yes, where? _____

Has your child been evaluated for or placed in any special classes (i.e., lab tutoring, remedial instructions, etc.)? ☐ Yes ☐ No

If yes, what services does he/she receive and how often? _____

_____

REHABILITATION HISTORY- ATTACH A COPY OF CURRENT OUTPATIENT THERAPIES GOALS, EVALUATIONS AND PLAN OF CARE

Has your child previously **received therapy**? ☐ Yes ☐ No
If yes, please provide the following information, beginning with the most recent:

Dates Attended	Location of Treatment	Therapy Type PT, OT, ST, MT Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST) Music Therapy (MT)	Therapist and Telephone #	Frequency of Treatment
to				
to				
to				
to				
to				

Is your child currently using any adaptive equipment? If yes, please bring equipment at time of admission.
☐ Yes ☐ No If yes, check all that apply

☐ Wheelchair
☐ Stander
☐ Splints/Braces
☐ Switches
☐ Communication device
☐ Feeding equipment
☐ Walker
☐ Positioning equipment
☐ Glasses
☐ Hearing aide
☐ Speaking valve
☐ Bathing equipment
☐ Other: (specialty beds, etc.) _____

Are there any concerns with equipment fitting or in good working condition? _____

_____

_____

What are your child's current functional abilities? _____

_____

What are your child's previous functional abilities? (ex, Completely independent, needs assistance with dressing)

_____

_____

Does your child have special transportation needs? (medical transport, medical car seat, etc.)? _____

_____

_____

Which of the following services do you feel would most benefit your child during admission? Any specific goals/concerns for each therapy?

☐ Physical therapy _____

_____

☐ Occupational therapy _____

_____

☐ Speech-language pathology _____

_____

☐ Music therapy _____

_____

☐ Recreation therapy_____

_____

SOCIAL SERVICES

Are there any services, equipment or information that would make caring for your child at home easier?

_____

_____

_____

_____

Signature_____Date_____

Every patient admitted to Bethany Children's Health Center is evaluated on admission to determine an individualized, specific plan of care to meet their rehab needs and goals. If you have further questions regarding this process please feel free to reach out to the admissions department at 405-470-2247 or Referrals@bethanychildrens.org.

Please return completed form to Bethany Children's Health Center 10-14 days prior to admission.

Bethany Children's Health Center
Donald W. Reynold's Complex
Attn: Admissions
6800 NW 39th Expressway
Bethany, OK 73008 or
Referrals@bethanychildrens.org or
Fax: 1-844-785-7681
Thank you for allowing us to care for your child.