Spinal Cord Optimization Program Application for Admission

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

Is your child adopted? Yes/No If yes, complete the following as completely as possible.

PREGNANCY

Pregnancy with this patient was: ☐ Normal ☐ With Complications (explain)

____

____

Any medical conditions that are in the family? (asthma, ADHD, heart disease, seizures,)

____

____

Who lives in the home with the patient currently?

____

____

Who is the primary caregiver for your child?

____

____

What are your main goals for an admission to the program?

____

____

MEDICAL HISTORY - ATTACH MOST RECENT HISTORY AND PHYSICAL (H&P) AND IMMUNIZATION RECORD

Current diagnosis/problems or concerns: ____

____

____

Level of Spinal Cord Injury:____

Current bladder program (mode, catheter size, frequency, and who performs cath)________________

____

Current bowel program (mode, medication, frequency, and who performs bowel program interventions)________

____

____

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: _________________________

Respiratory medications-please bring your child's current respiratory medications at the time of admission:

Medication	Dose	Route	Time given/frequency:
(ex:) Albuterol	Two puffs	By mouth	As needed

Airway clearance:

Treatment	Frequency	Other
(ex) Vest treatment	Twice a day	15 minutes

Major illnesses and hospitalizations: ____

____

____

____

Allergies: ____

____

Surgical procedures and dates: ____

____

____

____

____

Current diet: ____

Current height: _________________________________ Weight: ____________________________

Are immunizations up to date? Flu shot? ____

Seizures: Y/N If yes, frequency: ____

What does child do during seizure: ____

Rescue seizure medications: ____

Does your child experience autonomic dysreflexia? If yes, what medications or interventions are used? _______________

____

____/

Tracheostomy size/type: ____________________ Last change: __________ Frequency changed: ____________________

Non-invasive/invasive ventilation: ____________________ Ordered Settings: ______________________________

Oxygen requirements: ____

EDUCATION HISTORY – 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? ______________________________________

____

Does your child have a plan for transitioning through High School?______________________________

Has your child had a Visual Screening? ☐ Yes ☐ No

Results: ____

Has your child had a Hearing Screening? ☐ Yes ☐ No

Results: ____

What are your child's preferred leisure/play time activities? _____________________________________

____

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?
☐ 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 bed, etc.)_______________

If your child wears splints or braces, what is wearing schedule? _______________

What company orders and fits your child's equipment? _______________

What are your child's current functional abilities? _______________

____

What are your child's current functional limitations? _______________

____

Please mark all of the following that your child is able to perform at this time:

☐ head control
☐ rolling
☐ sitting with support
☐ sitting without support
☐ crawling
☐ standing
☐ cruising
☐ walking with assistance
☐ walking without assistance
☐ eating by mouth
☐ self feeds

Please describe your child's typical day/schedule

____

____

____

____

____

Does your child have any 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 ____

____

Education____

____

Recreation therapy____

____

SOCIAL SERVICES

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

____

____

____

____

Please list previous stays your child has had out of your home besides The Children's Center (i.e. evaluation, etc.).

Facility: ____ Dates: __________________

Reason: ____

Facility: ____ Dates: __________________

Reason: ____

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

Bethany Children's Health Center
Attn: Admissions
Donald W. Reynold's Complex
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.