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Dear Parents:

The attached questionnaires allow us to obtain key information in order to evaluate your concerns regarding your child's attention, behavior, and/or school related issues. Please complete the **Parent Assessment Scale** forms before your child's in-office consultation. This will ensure that we have the information necessary to evaluate your child.

In addition, it is crucial to obtain information from your child's teacher(s) regarding their performance in school. Your child cannot be properly evaluated and/or diagnosed without input from their teacher(s). Please ask your child's teacher(s) to complete the **Teacher Assessment Scale** forms. We are interested in assessing the child's school behavior, academic performance, and any interventions the school staff have attempted to help your child. The teachers may return the forms directly to you or they may send it to us via fax or mail. In addition, your child's Provider would like to review your child's **most recent report card**.

After reviewing the completed assessments, we will schedule a consultation appointment for you and your child. *Consultations are only scheduled on Tuesdays, Wednesdays, and Thursdays.*

Please return the completed assessments at your earliest convenience. We look forward to the opportunity to assist you and your child!

Best Regards,

Triage Department
Snellville Pediatrics, P.C.

Completed forms may be faxed to Rosie at (678) 344-1965 or emailed to rcontreras@snellvillepeds.com

1700 Tree Lane, Suite 110 • Snellville, GA 30078 • Telephone: (770) 972-0860 • Fax: (770) 972-0850

Celebrating Your Child's HealthSM

PATIENT NAME: _____ INSURANCE COMPANY: _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services: We expect that your insurance company will not pay for the item(s) that are listed below. Your insurance company will not pay for all of your health care costs. Your insurance company only pays for covered items and services when their rules are met. The fact that your insurance company does not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. **Right now, in your case, your insurance company will probably not pay for:**

1. VANDERBILT TESTING
2. _____
3. _____

BECAUSE:

1. It is not a covered service under your insurance policy.
2. This service may be applied your insurance deductible.
3. _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services knowing that you may have to pay for them yourself. Before you make a decision on receiving a service, you should read this *entire* notice carefully.

- Please ask us to explain if you don't understand why your insurance company probably won't pay for an item or service.
- Ask us how much these items or services will cost you (Estimated Cost: \$ _____) in case you have to pay for them yourself or through other insurance.

***PLEASE CHOOSE ONE OPTION. CHECK ONE 'BOX.' SIGN AND DATE BELOW.**

() Option 1. Yes, I want to receive these items or services. I understand that my insurance company may not pay for these items or services. Please submit my claim to my insurance company. I understand that Snellville Pediatrics will ask for payment at check out. If my insurance company does pay for these services, I will be refunded. I agree to be personally and fully responsible for payment. I also understand that I may appeal my insurance company's decision.

() Option 2. No, I have decided not to receive these items or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance won't pay.

Patient's Name

Date of Birth

Parent/Guardian Signature

Date



Pediatric Cardiac Risk Assessment Form

Complete this form for each person under the age of 50, including children, periodically during well child visits including neonatal, preschool, before and during middle school, before and during high school, before college and every few years through adulthood. If you answer "Yes" or "Unsure" to any questions, read the back of this form.

Name: _____ Age: _____ Date: _____

Individual History Questions:	Yes	No	Unsure
Has this person fainted or passed out DURING exercise, emotion or startle?			
Has this person fainted or passed out AFTER exercise?			
Has this person had extreme fatigue associated with exercise (different from others of similar age)?			
Has this person ever had unusual or extreme shortness of breath during exercise?			
Has this person ever had discomfort, pain or pressure in his chest during exercise, or complained of his heart "racing or skipping beats"?			
Has a doctor ever told this person they have: <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol <input type="checkbox"/> a heart murmur or <input type="checkbox"/> a heart infection? (Check which one, if any.)			
Has a doctor ever ordered a test for this person's heart? If yes, what test and when?			
Has this person ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma? If yes, which one and when?			
Has this person ever been diagnosed with any form of heart/cardiovascular disease? If yes, what was the diagnosis?			
Is this person adopted, or was an egg or sperm donor used for conception?			

Family History Questions (think of grandparents, parents, aunts, uncles, cousins and siblings):	Yes	No	Unsure
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (including SIDS, car accident, drowning, passing away in their sleep, or other)			
Are there any family members who died suddenly of "heart problems" before age 50?			
Are there any family members who have had unexplained fainting or seizures?			
Are there any family members who are disabled due to "heart problems" under the age of 50?			

Are there any relatives with certain conditions such as:			
Check the appropriate box: <input type="checkbox"/> Hypertrophic cardiomyopathy (HCM) <input type="checkbox"/> Dilated cardiomyopathy (DCM)			
Check the appropriate box: <input type="checkbox"/> Arrhythmogenic right ventricular cardiomyopathy (ARVC), <input type="checkbox"/> Long QT syndrome (LQTS), <input type="checkbox"/> Short QT syndrome, <input type="checkbox"/> Brugada syndrome, <input type="checkbox"/> Catecholaminergic ventricular tachycardia			
Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger)			
Check the appropriate box: <input type="checkbox"/> Aortic rupture or Marfan syndrome <input type="checkbox"/> Ehlers-Danlos syndrome			
<input type="checkbox"/> Primary pulmonary hypertension <input type="checkbox"/> Congenital deafness (deaf at birth)			
<input type="checkbox"/> Pacemaker or <input type="checkbox"/> implanted cardiac defibrillator (if yes, whom and at what age was it implanted?)			
Other form of heart/cardiovascular disease or mitochondrial disease			
Has anyone in the family had genetic testing for a heart disease? If yes, for what disease?			
Was a gene mutation found? Circle one: YES/NO			

Explain more about any "yes" answers here:

Physical Exam from Physician should include: (to be performed by a physician – made available here for the purpose of parent/patient education to ensure all evaluations have been completed)	Yes	No	Unsure
Evaluation for heart murmur in both supine and standing position and during valsalva			
Femoral pulse			
Brachial artery blood pressure – taken in both arms			
Evaluation for Marfan syndrome stigmata			

Unsure over if you answered "yes" or "unsure" to one or more questions



If you answered "yes" or "unsure" to one or more questions on this form, you may be wondering what to do next.

Step One – Contact your health care provider, normally your General Physician, Family Practitioner or Pediatrician and discuss the form. Talk about areas of risk you have identified and discuss having a full cardiac exam by a cardiac professional. Some physicians may be comfortable ordering cardiac testing and interpreting the results and some may not, therefore a referral may be needed to a cardiologist.

Step Two – Based upon your insurance provider, either ask your doctor for a referral for a complete cardiac evaluation by a cardiologist or seek the appointment on your own. This appointment should include basic cardiac testing based on the individual's history but normally includes a consult with the cardiologist, an electrocardiogram (ECG), echocardiogram (echo) and in some cases stress testing and additional cardiac imaging such as CT scans or cardiovascular magnetic resonance imaging (cMRI).

Step Three – Communicate your history to the rest of your family so they can seek appropriate screening.

Things you should know about additional testing for sudden cardiac arrest (SCA) risks:

1. Nearly all tests are painless, noninvasive and require no needles.
2. Tests are an evaluation of the heart at that moment in time and things may change over time, therefore you may need to repeat the testing on yourself or your child at intervals throughout life.
3. The knowledge of cardiac diseases that cause sudden cardiac arrest is evolving, and testing may change over time. The definition of normal or abnormal may also change.
4. If you and/or your loved one are found to be at risk for SCA, there are things you can do to help prevent SCA including:
 - a. Taking medication
 - b. Having an implantable cardioverter defibrillator (ICD) implanted (a pacemaker-like device that can provide a lifesaving shock if you experience SCA)
 - c. Making lifestyle modifications to reduce risk (for example, some may need to refrain from *competitive sports*)

Special note: If you answered "unsure" to questions about health history, discuss the details with complete candor with your health care provider. Cases of adoption, egg or sperm donation, or uncertain paternity are areas of specific concern as the health information that may have been available at the time of adoption, donation or last contact with the father may have changed and you may be unaware. We suggest that you err on the side of caution and seek baseline cardiac testing in these cases.

For more information:

Call Sibley Heart Center Cardiology at 404-256-2593 or 800-542-2233

Email info@kidsheart.com

Visit www.choa.org/cardiology to print additional copies.

NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD



Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name	Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.		Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
Part A						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking too much when you are in social situations?						
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
Part B						