SNELLVILLE PEDIATRICS, P.C.

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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

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

Children's SM
Healthcare of Atlanta
Dedicated to All Better

Sibley SM
Heart Center
CARDIOLOGY

PURPOSE STATEMENT FOR USE OF PEDIATRIC CARDIAC RISK ASSESSMENT FORM

The Cardiovascular Risk Assessment Form was developed for the purpose of identifying patients/families at risk for sudden cardiac arrest, due to the presence of underlying cardiac disorder. This form was developed through the collaboration of several organizations to identify warning signs and symptoms in the patient and family and possible physical findings that might alert the healthcare provider to the presence of one of these cardiac disorders.

This form is relatively extensive and requires complete and correct information from families completing the form. Questions shaded in gray represent questions that we believe are of more significance and concern; yes answers to these questions should prompt a referral for a comprehensive cardiac evaluation.

We have also seen through the years that there are FOUR KEY QUESTIONS that are more likely to identify patients affected by cardiac disorders predisposing to sudden cardiac arrest. These are:

1. **Have you ever fainted, passed out, or had a seizure suddenly without warning, especially during exercise or in response to auditory triggers such as door bells, alarm clocks, and ringing telephones?**
2. **Have you ever had exercise induced chest, shoulder, jaw or back pain during or immediately after exercise?**
3. **Are you related to anyone with sudden unexplained and unexpected death before the age of 50 years?**
4. **Are you related to anyone who has been diagnosed with a sudden death predisposing heart conditions such as hypertrophic cardiomyopathy, long QT syndrome, or CPVT?**

You may also be interested in two recent articles that provide more detail about pediatric sudden cardiac arrest, with specific emphasis on identification of patients and/or family members potentially affected by these cardiac disorders. If you would like a reprint of either article, please contact Richard Lamphier at richard.lamphier@choa.org. These publications are listed below:

1. Campbell RM, Berger S, Ackerman MJ. "Pediatric Sudden Cardiac Arrest". *Pediatrics* Vol. 129 No. 4 April 1, 2012. pp. e1094-e1102.

2. Dalal A, Czosek RJ, Kovach J, von Alvensleben JC, Valdes S, Ethridge SP, Ackerman MJ, Auld D, Huckaby J, McCracken C, Campbell R. Clinical Presentation of Pediatric Patients at Risk for Sudden Cardiac arrest. J *Pediatr.* 2016 Oct;177:191-6.

This form includes all screening questions suggested in the American Heart Association Recommendations for Preparticipation Screening for Cardiovascular Abnormalities in Competitive Athletes — *Circulation* 2007:115

For more information, visit choa.org/cardiology, email info@kidsheart.com or call 404-256-2593 (800-542-2233).

TURN FORM OVER TO COMPLETE ASSESSMENT

Children's Healthcare of Atlanta
Dedicated to All Better

Sibley Heart Center CARDIOLOGY

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, shoulder, back or jaw during exercise, or complained of their heart "racing or skipping beats"?			
Has a doctor ever told this person they have: ☐ high blood pressure ☐ high cholesterol ☐ a heart murmur or ☐ a heart infection? (Check all that apply)			
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):			
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 <u>any</u> relatives with certain conditions such as:			
Check the appropriate box(es): ☐ Hypertrophic cardiomyopathy (HCM) ☐ Dilated cardiomyopathy (DCM) ☐ Arrhythmogenic right ventricular cardiomyopathy (ARVC) ☐ Long QT syndrome (LQTS) ☐ Short QT syndrome ☐ Brugada syndrome ☐ Catecholaminergic polymorphic ventricular tachycardia ☐ Aortic rupture or Marfan syndrome ☐ Ehlers-Danlos syndrome ☐ Primary pulmonary hypertension ☐ Congenital deafness (deaf at birth)			
Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger)			
☐ Pacemaker or ☐ 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:	**Normal**	**Abnormal**
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		

Questions shaded in gray represent questions that we believe are of more significance and concern and a referral for cardiac evaluation should be considered.

Person Completing Form: _____
Print Name

Updated 05.11.17

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