



The Knights of Columbus Developmental Center

1465 S. Grand Blvd. St. Louis, MO 63104

Phone: (314) 577-5609 Fax: (314) 268-4028

Dear Parent or Guardian,

Thank you for your inquiry to our center concerning your child's development. We are a physician-referral clinic, which means your child's pediatrician or primary care physician needs to refer your child to our clinic for evaluation and/or treatment.

Enclosed in this packet are a **parent intake questionnaire** and a **physician referral form**. Please complete the parent intake questionnaire yourself, and please have your child's physician complete the referral form. After both forms are completed, please return them to our center. Once we have received both forms, we will review them and determine if our center is the appropriate place for your child. **We will only review completed packets (both the parent intake questionnaire and the physician referral form)**. If it is decided that we can meet your child's needs, we will place your child on our wait list. If it is decided that our center is not the best place for your child, you should contact your primary physician for further direction. In either case, we will mail you a letter indicating your child's status.

Please be advised that we have an extensive wait list, and as such, it is important for you to stay in contact with your child's pediatrician or primary care provider for care and additional resources and referrals.

If your child is younger than 3 years and has not been evaluated for concerns regarding his/her development, please contact the early intervention program in your state to begin the process of evaluation. In Missouri, the program is "First Steps" (1-866-583-2392). In Illinois, the program is "Child and Family Connections" (1-800-323-GROW). These early intervention programs provide free evaluations and therapies (speech/language, motor, developmental) for children with developmental delays. Similarly, children between the ages of 3 and 6 can be evaluated through your local Department of Special Education, and may be eligible for pre-school early intervention services at no cost to your family.

Thank you again for your interest in our center. We look forward to helping your child.

Sincerely,

The Staff and Faculty of the Knights of Columbus Developmental Center
SSM Cardinal Glennon Children's Medical Center

Knights of Columbus Developmental Center at SSM Cardinal Glennon Children's Medical Center

Parent Intake Questionnaire (Please print clearly)

Date: _____

Referred by: _____

Specialty: _____

Child's Name: _____

Date of Birth: _____

Child's Race/Ethnicity: American Indian, Asian, African American, Caucasian, Hispanic, Other _____

Street Address: _____ City: _____ State: ___ Zip: _____

Mother's Name _____

DOB: _____

Father's Name _____

DOB: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Alternative number: _____

Insurance Plan/Name: _____ Policy #: _____ Group# _____

Policy Holder: _____

1. Has child's mother, father or siblings been diagnosed with a form of Autism Spectrum Disorder (e.g., Autism, Asperger's Syndrome, Pervasive Developmental Disorder)? YES/NO

2. Has anyone diagnosed your child with a form of Autism Spectrum Disorder? YES/NO

If yes, what is the specific diagnosis? _____

If yes, who made the diagnosis? _____

3. Has anyone had any concerns that your child may have an Autism Spectrum Disorder? YES/NO

If yes, who is concerned and why? _____

4. What concerns do you have about your child's development? Please be specific.

5. Are there things your child was able to do before that he/she is not able to do now? YES/NO

If yes, what are those things? _____

6. Are there concerns that your child may have ADHD (Attention Deficit Hyperactivity Disorder)? YES/NO

If yes, who is concerned and why? _____

7. Are there concerns that your child may have a learning disability? YES/NO

If yes, who is concerned and why? _____

8. Do you have behavioral concerns about your child? YES/NO

If yes, what are the specific concerns? _____

9. Has your child seen any health care professionals for any of your concerns? YES/NO

If yes, who has your child seen? _____

10. Please list **all** of your child's diagnoses (e.g., genetic, developmental, medical, educational, psychiatric, etc.):

11. Please list all medications your child is taking:

12. Please list all services your child is receiving (speech-language therapy, occupational therapy, ABA, psychotherapy):

13. Has your child made any statements about hurting him/herself, others, or animals? YES/NO

If yes, please make an urgent appointment with your child's primary care provider or take your child to an emergency room.

14. Does your child have any symptoms or a diagnosis of depression, anxiety, obsessive compulsive disorder, oppositional defiant disorders, bipolar disorder or any other psychiatric concerns? YES/NO

If yes, which symptoms or diagnoses does your child have? _____

If yes, please contact your community psychiatrist or SSM Central intake at 314-344-6700.

15. What questions about your child do you hope to have answered with an evaluation at this clinic?

16. Does your child (Please check all that apply):

- | | | | |
|--|--|--|----------------------------------|
| <input type="checkbox"/> yes <input type="checkbox"/> no | Get along with other children | <input type="checkbox"/> yes <input type="checkbox"/> no | Prefer to be alone |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Get along with adults | <input type="checkbox"/> yes <input type="checkbox"/> no | Avoid eye contact |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Play social interactive games | <input type="checkbox"/> yes <input type="checkbox"/> no | Have difficulty expressing needs |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Initiate play with other children | <input type="checkbox"/> yes <input type="checkbox"/> no | Insist on sameness and routine |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Use gestures (point, wave, shrug, nod) | <input type="checkbox"/> yes <input type="checkbox"/> no | Have attachments to odd objects |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Have a sense of humor | <input type="checkbox"/> yes <input type="checkbox"/> no | Spin objects or self |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Understand social cues | <input type="checkbox"/> yes <input type="checkbox"/> no | Exhibit repetitive movements |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Give/accept hugs & kisses | <input type="checkbox"/> yes <input type="checkbox"/> no | Shows unusual play |
| <input type="checkbox"/> yes <input type="checkbox"/> no | Turn to his/her name | <input type="checkbox"/> yes <input type="checkbox"/> no | Excessively fearful or anxious |

Thank you for completing this form.



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Dear Physician,

Thank you for referring your patient to The Knights of Columbus Developmental Center for a developmental consultation. We offer diagnostic evaluations for a variety of developmental concerns.

The Knights of Columbus is strongly committed to the involvement of the family physician or pediatrician in the care of patients with developmental disorders. Your input is vital, and we cannot schedule appointments without it. Please complete the **Physician Referral Form** for the family to return to our center, along with the **Parent Intake Questionnaire** that they have completed. When both forms are received, our triage staff will review the request and make a clinic assignment or recommend other agencies that may be appropriate. Either way, we will keep you informed.

Please Note: We cannot accept referrals for diagnosis or treatment of disorders that are primarily psychiatric (bipolar disorders, anxiety disorders, oppositional defiant disorder, conduct disorder, personality disorders, etc.).

Thank you again for your interest in our center. Please do not hesitate to contact us with any questions.

Sincerely,

The Staff and Faculty of the Knights of Columbus Developmental Center
SSM Cardinal Glennon Children's Medical Center

**SSM Cardinal Glennon Children's Medical Center
Knights of Columbus Developmental Center**

Physician Referral Form

Thank you for choosing to refer your patient to us for consultation. To start the referral process, please complete this form and return it to the parent, along with any relevant medical records.

Name of Patient: _____

DOB: _____

Consultation Request Information:

Name of Referring MD: _____

Phone: _____

FAX: _____

Address to which consultation report should be sent:

Address: _____

City: _____

State: _____

Zip: _____

Reason for Referral:

Screening Completed: Please check what screening was completed. For those screenings completed, please indicate whether the child passed or failed them, and send copies of evaluations.

Modified Checklist for Autism in Toddlers (M-CHAT)

Pass/Fail

Conner's Behavior Ratings Scales

___ Parent; Pass/Fail ___ Teacher; Pass/Fail

Ages and Stages Questionnaire (ASQ)

Pass/Fail

Parents' Evaluations of Developmental Status (PEDS)

Pass/Fail

Social and Communication Questionnaire (SCQ)

Pass/Fail

Vanderbilt Scales

___ Parent; Pass/Fail ___ Teacher; Pass/Fail

Child Development Inventories/Ireton

Pass/Fail

Childhood Asperger Screening Test (CAST)

Pass/Fail

Pertinent Medical History:

Please describe dysmorphic features (if applicable):

Laboratory or Radiological Studies Completed: Please check what studies have been completed, and for those studies completed, please indicate if they were normal or abnormal. If any were abnormal, please include a copy of results.

- | | |
|---|--|
| <input type="checkbox"/> EEG; Normal/Abnormal
Date: _____ | <input type="checkbox"/> MRI brain; Normal/Abnormal
Date: _____ |
| <input type="checkbox"/> Vision Screen; Normal/Abnormal | <input type="checkbox"/> Hearing Screen; Normal/Abnormal |
| <input type="checkbox"/> Chromosomal Testing; Normal/Abnormal | <input type="checkbox"/> Lead Level; Normal/Abnormal |
| <input type="checkbox"/> Other: _____ | |

Concerns Related to Family/Social History?

The Child Has Been Referred To: (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> Parents as Teachers | <input type="checkbox"/> Early Childhood Special Education |
| <input type="checkbox"/> Speech/Language Therapy | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Genetics | <input type="checkbox"/> Ophthalmology |
| <input type="checkbox"/> Psychology | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Other _____ |

If the child is younger than 3 years, please refer to Early Intervention (First Steps in MO; Child and Family Connections in IL).

If the child is older than 3 years, please refer to Special Education Department in his/her school district.

Current Diagnoses (if any):

Diagnosis: _____ ICD-9 Code: _____

Diagnosis: _____ ICD-9 Code: _____

Diagnosis: _____ ICD-9 Code: _____

Please send a copy of the child's growth chart, as well as any other medical records you feel would be helpful.

Signature of Referring Physician: _____ Date: _____

Thank you for your referral.