Dear Parent/Guardian,

Welcome to ***Developmental and Behavioral Pediatrics of the Carolinas***. We would like to introduce you to your future care team. At your first evaluation you and your child will meet your child's Developmental and Behavioral Pediatrician. At your future visit, you will meet your child's Developmental and Behavioral Advanced Practice Provider. This care team will collectively develop a treatment plan specific to the needs of your child and provide access to the best Pediatrics Developmental and Behavioral Services.

Concord Provider Team
Joseph Stegman, MD
Mark Clayton, MD
Shruti Mittal, MD
George "Wes" Hatley, PA-C
Angela Noone, MSN, CPNP

Charlotte Provider Team
Yasmin Senturias, MD
Tsehaiwork "Sunny" Fenikile, MD
Shruti Mittal, MD
Monique Sutton, MSN, CPNP
Ryan Grimes, MSN, CPNP

Enclosed you will find our new patient information and assessment inventories that must be completed and returned prior to an appointment being scheduled. Please be sure to thoroughly read and complete the contents of this packet. A checklist is enclosed for your convenience. Some pages may be double-sided. If you need help completing the packet, please contact your PCP or our clinic.

Please note, if we do not receive a completed packet this will delay the packet review and scheduling process. With the increased needs for our services and the large number of referrals we receive monthly, please note a fully completed packet, once received by the practice, will take an additional 4-6 weeks to review. At that time, you will be contacted by one of our teammates to schedule your appointment.

Please mail, fax, or drop off your completed packet to our Concord Office:

301 Medical Park Drive
Ste 202B
Concord, NC 28025
Office (704) 403-2626
Fax: (704) 403-2699

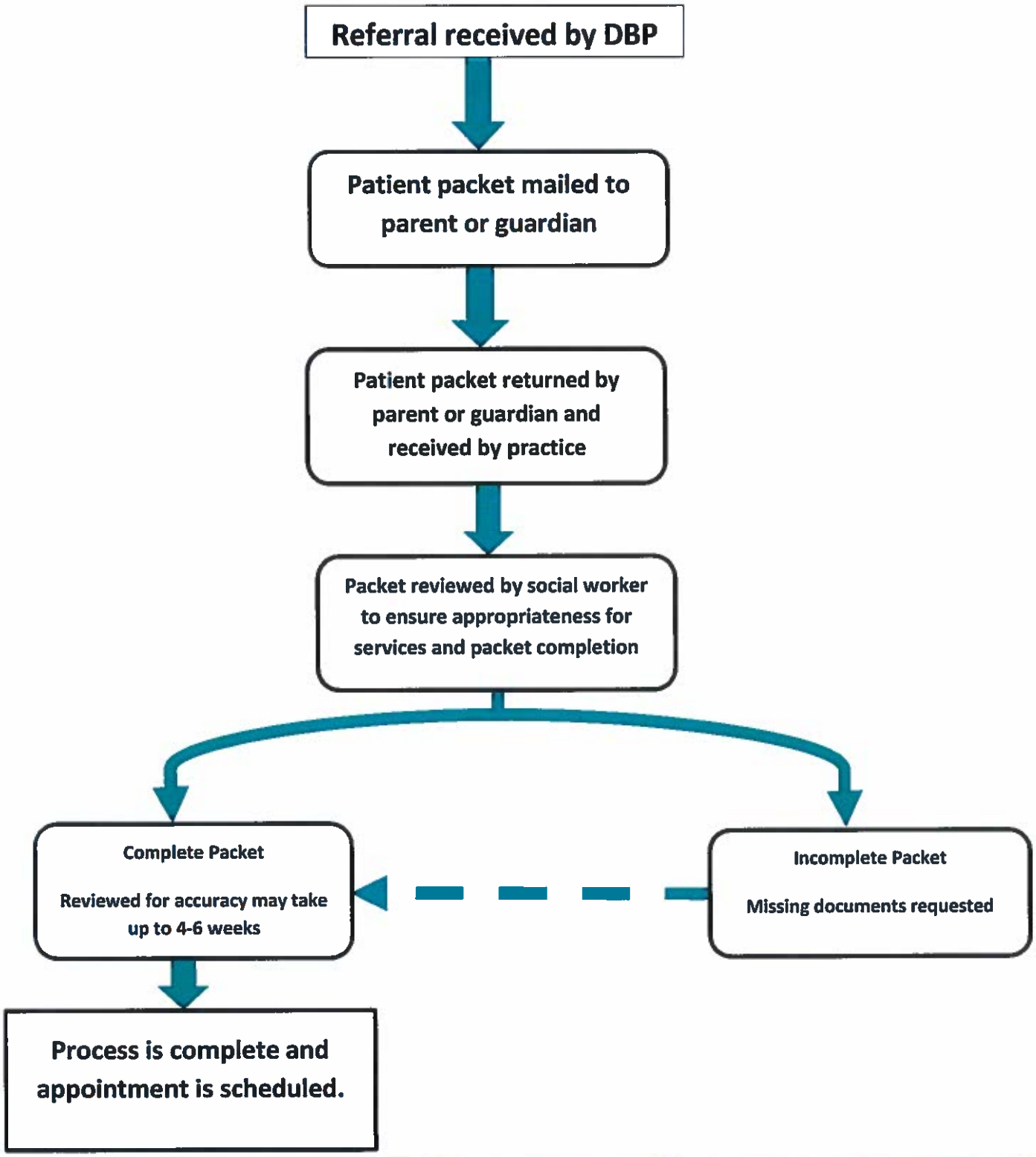
All referrals are time sensitive. Please return as soon as possible. The sooner we receive a completed packet the sooner we can place it in review. If you need assistance completing the packet, please call our office at 704-403-1653.

For more information about our practice, please visit our website:
https://atriumhealth.org/locations/developmental-and-behavioral-pediatrics-of-the-carolinas
Thank you for allowing us to participate in your child's health care needs. We look forward to meeting you.

Yours in Health Care,
Physicians and Care Team of
Developmental and Behavioral Pediatrics of the Carolinas

Developmental and Behavioral Pediatrics of the Carolinas

Referral Process



PAPERWORK CHECKLIST

We have enclosed this paperwork checklist to help you with your packet. To avoid delays in scheduling an appointment, please submit **ALL** items on the list that is relevant to your child. The below items are requested so that our providers may complete a thorough evaluation of your child. Please be aware that the provider may request additional evaluations before or after the initial consult for diagnostic clarification.

Please review front and back of each document to ensure they are complete.

- ☐ **Family Information Sheet**
- ☐ **Patient History Forms**
- ☐ **Previous Evaluations and Records of Treatment:**
  - Speech Therapy
  - Occupational (OT) Therapy
  - Physical (PT) Therapy
  - Behavioral Therapy
  - Counseling
  - Children Developmental Service Agency (CDSA)
  - Medication History (Prescribing Physician and Medication List)
- ☐ **Legal Documentation** if you are a foster parent, grandparent, or guardian, we will need copies of legal custody paperwork
- ☐ **Insurance Card** (Send a copy of the front & back of the card)

*****MAIL ALL FORMS TO THE CONCORD LOCATION*****

Please note any other special needs: _____

If interpreter is required, please specify language: _____

Please select the location you would like your appointment scheduled:

☐ **Concord**
301 Medical Park Drive
Ste 202B
Concord, NC 28025

Physicians at Location
Joseph C. Stegman, MD
Mark C. Clayton, MD
Shruti Mittal, MD

☐ **Charlotte**
2608 East 7th Street
Charlotte, NC 28203

Physicians at Location
Yasmin S. Senturias, MD FAAP
Tsehaiwork "Sunny" Fenikile, MD
Shruti Mittal, MD

Developmental & Behavioral Pediatrics of the Carolinas.

Making the Most of Your Visit

To ensure a thorough and productive evaluation of your child, we request to you bring only your child scheduled for the visit. Please refrain from bringing the patient's siblings or other children to the appointment. If you must bring siblings, we kindly ask that you bring a responsible adult to accompany them in the waiting room during this time. This limits distractions and allows us to focus on your concerns for your child.

Due to the high volume of patients requiring our specialized services, our clinic has established the following guidelines regarding cancellations, no shows, and late arrivals. The policy is as follows:

Cancellations & No Shows

5. Please contact us for cancellations within 24 hours of the scheduled appointment time. This allows the office to schedule another patient in need of an appointment.

6. Appointments not cancelled within 24 hours or failure to attend a schedule appointment will be considered a ***"no show"***

7. Patients with **Three (3) no show** appointments within a 12-month period are subject to dismissal from the practice.

8. Patients with **Two 2 no show** appointments for initial evaluations (consults) will result in the dismissal of the patient's referral.

Late Arrivals

2. Patients who arrive ***10 minutes*** after their scheduled appointment time will be considered late. As the discretions of the provider, patients may be seen with a reduced visit time or may be required to reschedule their appointment.

We appreciate your cooperation and look forward to meeting you and your child.

704-403-2626

Developmental & Behavioral Pediatrics of the Carolinas
Family Information

Patient Information

Last Name	First	Middle	Sex ☐ Male ☐ Female
Date of Birth	Social Security No	*SS # needed for ALL Medicaid patients*	
Address	City	State	Zip Code
Primary Language ☐ English ☐ Spanish ☐ Other	Race		

Primary Custody/ Guardianship (Guardians will need to send copy of legal Documents)

☐ Parents ☐ Father ☐ Mother ☐ Grandparent ☐ Foster Care

Father/ Guardian Information

Last Name	First	
Date of Birth	Social Security No	
Address ☐Same as above		
Street	City	Zip Code
Home Phone No.	Mobile No.	
Employer	Work No.	

Mother/Guardian Information

Last Name	First	
Date of Birth	Social Security No	
Address ☐Same as above		
Street	City	Zip Code
Home Phone No.	Mobile No.	
Employer	Work No.	

In Case of Emergency

Name	Relationship to patient	Phone No.
Name	Relationship to patient	Phone No.

Insurance Information (send copy of front and back of card)

Primary Insurance Company Name

Subscriber Information

Name	Date of Birth	Social Security No.

Secondary Insurance Company Name

Subscriber Information

Name	Date of Birth	Social Security NO.
NC Medicaid ID No.	Social Security No.	

Permission for child to receive medical treatment

If I can't come with my child, I agree to let (person name)

I give permission to the above person to give permission for any treatment. Please Initial _____

Care Team Provider prefers a Parent to be present at all visits. This is for (in case of an emergency).

Signature of person completing form _____ **Date** _____

Atrium Health

Today's Date: _____

DEVELOPMENTAL & BEHAVIORAL PEDIATRICS FORM- PLEASE COMPLETE ENTIRE FORM

Child's Name: _____ Date of Birth: _____

Name Child wants to be called: _____

PATIENT HISTORY FORM

Name of person completing this Form: _____ Relationship to Child: _____

PURPOSE OF THE VISIT

Describe what concerns you have about your child: _____

_____

Previous Evaluations for these concerns: (Examples: School, CDSA, Psychiatrists, Psychologists, Neurologists, Genetics, Speech, OT, PT) _____

_____

What would you most like to happen with this this visit: _____

What questions do you have for the doctor?: _____

_____

Does he/she currently have an Individualized Education Program (IEP)? Yes/No OR Section 504 Plan? Yes/No

List any services your child is currently receiving: _____

(Speech/Occupational Therapy/Physical Therapy, ABA, special services through the school, 504, behavioral therapy)

CHILD'S HISTORY (fill out or encircle Yes/No items)

Describe your child's overall health/growth: _____

Describe Your Child's Growth: _____

Describe Your Child's Temperament: _____

Birth Weight: _____pounds _____ounces

Circle which of these describe your pregnancy: Full term / Premature (____ weeks) / induced / vaginal delivery / C-section.

Were there any complications while you were pregnant or during birth? _____

_____

Hospitalizations/surgeries/chronic illnesses: _____

_____

Head injuries: _____ Seizures? Yes/No _____

ALLERGIES/ DRUG ALLERGIES: _____

When did your child begin school or preschool: _____ Repeated Grade: _____

Current School: _____ Grade: _____

PAST MEDICATIONS: If your child has been on any medications in the past, list with dose and reactions: (ex. Vyvanse: decreased appetite):

_____ _____

_____ _____

CURRENT MEDICATIONS (Name + Dose + When/how often):

_____ _____

_____ _____

_____ _____

DEVELOPMENTAL AND EDUCATIONAL HISTORY:

Describe concerns about your child's development: _____

_____

_____

At age did you first suspect difficulties? _____

Did your child lose any developmental skills at any point in time? _____

By what age did your child begin to do the following activities listed below?

MOTOR

Crawl: _____

Sit without support: _____

Walk alone: _____

Ride a bicycle without training wheels: _____

Walk up and down stairs: _____

LANGUAGE

Respond to name: _____

Said first word (with meaning) _____

Put 2 words together: _____

Talk about his/her day: _____

Pretend play with others: _____

SOCIAL/SELF HELP

Smile in response to others: _____

Use a spoon to feed self: _____

Bladder/bowel trained: _____

Play with others: _____

Able to separate from parent/caregiver: _____

Able to dress oneself: _____

When did your child begin school or preschool: _____ Repeated Grade: _____

CURRENT SCHOOL: _____ Grade: _____

Learning challenges (all subjects/list) _____

_____

In the list below, please circle one or more of the following behaviors your child has:

Self-regulatory: Feeding Problems (eating too much or too little/ no variety) / sleep problems (with or without snoring) / eating non-foods, hyperactive.

Social: Shyness with strangers/ bashfulness with other children/ poor eye contact/ failure to be affectionate.

Emotional: Temper tantrums/ irritability/ crying often and easily/ tendency to be overexcited/ difficulty getting consoled.

Sensory: High threshold for pain/ oversensitive to noises/ oversensitive to textures of food, clothing or light.

Aggression/self-injurious: head banging/ hurting self/ physical aggression to others.

Motor behaviors: repetitive movements/ motor tics/ vocal tics.

Others: problems with changes in routine, fixation on items, refusal to go to school.

REVIEW OF SYSTEMS

In the list below, please circle any problems your child has or has had in the past:

Chronic Pain	Unexplained Fevers
Weight Loss	Cancer
High Cholesterol	Cataracts
Crossed Eyes	Chronic Ear infections
Chronic Sinus Infections	Chronic Allergic symptoms
Heart Murmur	Other Heart Problems
Asthma	Bronchiolitis
RSV	High Blood Pressure
Chronic Bronchitis	Cystic Fibrosis
Other Lung Disorders	Chronic Diarrhea
Chronic Constipation	Reflux
Ulcer	Other stomach or bowel problem
Joint problems	Muscle Problems
Skin Problems	Chronic Eczema
ADHD	Learning Disabilities
Intellectual Disability	Autism
Seizures	Cerebral Palsy
Depression	Anxiety
Kidney or Bladder infections	Other kidney disease
Diabetes	Thyroid problems
Other glandular problems	Sickle Cell Anemia
Anemia	Other blood disease

Other(s) (please list): _____

FAMILY HISTORY:

Who in the family has any of the following difficulties? (only include biological family)
(This would include child's father, mother, brothers, sisters, grandparents, aunts, uncles and first cousins.)
Please indicate the family member related to the appropriate items below:

ADHD:	Autism spectrum Asperger:
Trouble learning:	Bipolar Disorder:
Intellectual Disability:	Schizophrenia:
Repeated a grade in school:	Seizures:
Speech problems:	Drinking or drug abuse:
Behavior problems in school:	Birth Defects/died as infant or child:
Anxiety:	Tics or Tourette's syndrome:
Depression:	Vision Impairment/ Hearing Impairment:

SOCIAL HISTORY:

PARENTS: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other _____

Who does the child live with? _____

Child's Relationship with Mother: _____

Child's Relationship with Father: _____

Siblings, names and ages: _____

Family circumstances: _____

Biological Father:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

Biological Mother:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

ADOPTION INFORMATION (IF APPLICABLE):

Is the child adopted? _____ At what age? _____

Circumstances of Adoption: _____

Adoptive Father:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health: _____

Adoptive Mother:

Name: _____ Age: _____

Present Occupations: _____ School level completed: _____

General Health _____

Has this child been in Foster Care? _____

Circumstances of Foster Care: _____

Foster Parents: _____

Total Number of foster placements? _____