Brenner Children's

Amos Cottage
Therapeutic Day Program

3325 Silas Creek Parkway
Winston-Salem, NC 27103
p 336.713.7497
f 336.702.9199
www.wakehealth.edu/locations/clinics/t/therapeutic-day-program

Dear Parent(s)/Guardian(s):

Thank you for your interest in the Amos Cottage Therapeutic Day Program. Enclosed you will find the admission application which includes:

Forms to be completed by parent/guardian

- Admission Assessment *(to be completed by parent/guardian)*
- Referral Form completed and signed by Primary Care Provider
- UCLA PTSD Assessment (to be completed by parent/guardian)
- Financial Coverage & Assistance Request *(to be completed by parent/guardian)* ***Please fill out estimated yearly income.***
- Authorization for Use of Disclosure of Protected Health Information for Primary Care Provider
- Authorization for Use of Disclosure of Protected Health Information for School/Daycare
    - Child's name and date of birth at top of form
    - Name & address of facility to share information with (either doctor's office or school/daycare)
    - Parent/guardian signature & date signed, and relationship to child

Please also include any guardianship and/or custody paperwork (if applicable)

Forms to be completed by school/daycare

- School Information Request (3 pages)
- School Behavioral Intervention Plan (2 pages)
- If applicable, please include other supporting documentation from school/daycare, such as an IEP, psychological evaluation, speech/language evaluation, etc.
- Teacher's email address

Both parent and teacher will be receiving separate emails with a link to an online assessment from Q-global. Please click on the link and complete the assessment.

If you have any additional questions, please contact me at (336) 713-7497.

We look forward to working with you and your child.

Sincerely,

Cindy DiNicolas
Administrative Assistant
Amos Cottage Therapeutic Day Program
Atrium Health Wake Forest Baptist
Ph: (336) 713-7497
Fax: (336) 702-9199
cldinico@wakehealth.edu

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program Referral Form

Please fax completed form and records to Amos Cottage TDP Administrative Assistant at 336-702-9199

Date of referral: _____ Reason for referral:_____

Name: _____
(First) **(Middle)** **(Last)**

Date of birth: _____ **Sex:** _____ **Race:** _____

Custody other than Parents/Legal Guardians: (Department of Social Services) N/A
(note agency, provider)

Parents/Legal Guardian _____

Address: _____

County: _____

Primary telephone: _____ **Secondary telephone:** _____

Referring Physician/Psychiatrist:/Community Provider/MCO: _____

Practice Name: _____

Address: _____

Telephone: _____ **Fax:** _____

Contact e-mail: _____ **Group NPI number:** _____

Has Parent/Caregiver shared any behavioral, social, or emotional concerns regarding this patient:
_____
_____
_____
_____

Current medications: _____
_____
_____

Comments/Additional information:
_____
_____

Provider Signature: _____

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
Admission Assessment

Childs Full Name: _____

Date of Birth: _____ Race: _____ Gender: _____

Social Security Number: _____

Mothers' Name: _____ Date of Birth: _____

Fathers' Name: _____ Date of Birth: _____

Name and address of person with whom the child resides (include street, city, and zip code):

_____

_____

_____

County of Residence: _____ Home Phone: _____

Email Address: _____

Parents (check one): ☐ Married ☐ Unmarried ☐Separated ☐ Divorced ☐ Widowed

Who has legal custody of the child? _____

Please list all persons living in child's home and their date of birth:

_____

_____

_____

Mothers' occupation: _____ Mothers' work phone: _____

Mothers' employer: _____ Highest school grade completed: _____

Fathers' occupation: _____ Fathers' work phone: _____

Fathers' Employer: _____ Highest school grade completed: _____

INSURANCE INFORMATION:

Child's Insurance Provider: _____

If Medicaid, list what type of Medicaid and Medicaid number: _____

_____

Amos Cottage Therapeutic Day Program
Admission Assessment

PRE-SCHOOL/SCHOOL HISTORY

Does your child attend daycare, preschool, or school? _____ If yes, list name and address of program and how long child has been enrolled: _____
_____

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other?) _____
If so, explain: _____
_____

Does your child have an IEP? _____ Has the IST process started? _____ **(If your child has an IEP, kindly provide the program with a copy)**

Do you think your child needs additional support in school? _____ If so, explain: _____
_____
_____
_____

BIRTH/MEDICAL HISTORY

Were there problems during the pregnancy, labor, or delivery? _____ If so, explain: _____
_____

How many weeks or months was the pregnancy? _____ Baby's birth weight: _____

Birth was (check one): ☐ Normal ☐ Cesarean ☐ Breech ☐ Twins or more

Did baby have problems after birth? _____ If yes, please explain: _____
_____

Please list any major illnesses or injuries your child has had to this date: _____
_____

Is your child taking any medications regularly? _____ If yes, please list: _____
_____

Child's Primary Care Physician (Name/Address/Phone): _____
_____

List any other doctors/evaluators who have treated your child (Include name/address/phone): _____
_____
_____

Has your child ever been hospitalized? _____ If so, where? _____
Reason for hospitalization? _____
_____

DEVELOPMENTAL HISTORY

At what age did your child roll over _____ Sit Alone _____ Pull up to furniture _____ Crawl _____ Walk _____
Say Single Words _____ Say 3-word sentences _____ Become Toilet Trained _____

Amos Cottage Therapeutic Day Program
Admission Assessment

PLEASE CHECK THE AREAS THAT CURRENTLY CONCERN YOU ABOUT YOUR CHILD

GROSS MOTOR SKILLS:
☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

FINE MOTOR SKILLS:
☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

SELF-HELP SKILLS:
☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/Drying hands independently

STRENGTH AND MUSCLE TONE:
☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

SENSITIVITIES:
☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

SEEKS SENSATION:
☐ Chews clothes ☐ Enjoys/Makes strange noises ☐ Can't sit still/Fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

LISTENING SKILLS:
☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

COGNITIVE LEARNING:
☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend

ATTENTION/ACTIVITY LEVEL:
☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

SOCIAL/EMOTIONAL:
☐ Expressing feelings verbally: ☐ Happy ☐ Sad ☐ Angry ☐ Afraid
☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

OTHER:
☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

Amos Cottage Therapeutic Day Program
Admission Assessment

REFERRAL CONCERNS:

What are your primary concerns about your child? _____
_____

What have you been told regarding these concerns? (by your child's doctor, etc.) _____
_____
_____

Has your child received a behavioral or medical diagnoses? _____ If yes, please note: _____
_____
_____

What would you like to see done for your child during this admission? _____
_____
_____
_____

How can this program support you as a parent/caregiver? _____
_____
_____
_____

Who referred you to the Therapeutic Day Program? _____

Name of person completing this form: _____

I do hereby give my permission, as this child's parent/guardian, to have him/her treated/evaluated by the Amos Cottage Therapeutic Day Treatment Team. I understand that this facility is both a service and a training program and give my consent to have fully-supervised students participate in the evaluation.

Parent/Guardian (Print Name): _____

Signature: _____ Date: _____

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

UCLA PTSD REACTION INDEX for DSM-5 – PARENT/CAREGIVER REPORT

Child/Adolescent Name:_____ ID#_____ Age: _____ Sex: Girl ☐ Boy ☐
Grade in School _____ School: _____ Teacher:_____ City/State:_____
Interviewer Name/I.D._____ Date (*month, day, year*) ____/____/_____ (Session #_____)

TRAUMA/LOSS HISTORY SCREENING QUESTIONS: Place a check mark in the box on the left for each type of trauma/loss experience that has occurred.

	TRAUMA/LOSS HISTORY SCREENING QUESTIONS
☐	**Serious Accidental Injury:** Has your child ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where he/she or someone else was or could have been badly hurt or killed? Has he/she ever seen a bad accident where someone was badly hurt or killed?
☐	**Illness/Medical Trauma:** Has your child ever been so sick that you and he/she (or people taking care of him/her) were scared that he/she might die? Did he/she have a medical treatment that was very scary or painful? Did he/she ever see someone he/she really cared about get so sick that he/she was scared the person might die?
☐	**Community Violence:** Has your child ever seen a bad fight or shooting in his/her neighborhood, like between gangs? Was he/she afraid of getting badly hurt or killed? Has he/she ever seen someone mugged, robbed, stabbed or killed in his/her neighborhood?
☐	**Domestic Violence:** Has your child ever seen adults he/she lives with get in a bad fight with each other, where someone got punched, kicked, or hit with something? Have adults he/she lives with threatened to hurt each other? Has he/she ever seen an adult he/she lives with forced to do something sexual by another adult he/she lives with?
☐	**School Violence/Emergency:** Was your child ever at school when something really scary happened, like a shooting, a stabbing, a fire, where he/she or someone else got badly beaten up or someone attempted or committed suicide?
☐	**Physical Assault:** Has your child ever been badly physically hurt (punched, kicked, stabbed) by someone outside of his/her family or who was not taking care of him/her? Has your child ever been badly hurt by someone outside of his/her family, like someone in their neighborhood, a boy or a girl fried or a stranger?
☐	**Disaster:** Has your child eve been in a natural disaster, like a hurricane, tornado, earthquake, flood, or wildfire where he/she was hurt or could have been hurt or killed? Has your child been in a natural disaster where he/she saw someone badly hurt or killed? Has your child been in a place where there was a chemical spill or explosion?
☐	**Sexual Abuse:** Did someone who was taking care of your child ever force him/her to do something sexual? Did someone taking care of your child ever make him/her watch something sexual?
☐	**Physical Abuse:** Has your child ever been badly hurt (punched, kicked, stabbed, shaken) by someone in his/her family (like a parent, brother, or sister) or someone who was taking care of him/her? Has your child seen another child in his/her family being badly physically hurt by a parent, caregiver or legal guardian?
☐	**Neglect:** Has there ever been a time when someone who should have been taking care of you child didn't, like didn't take him/her to a doctor when he/she was really sick, left him/her alone for too long, didn't make sure he/she was going to school or didn't do their best to keep him/her healthy or safe?
☐	**Psychological Maltreatment/Emotional Abuse:** Did anyone in your child's family ever keep telling him/her that he/she is no good, keep yelling at him/her or keep threatening to leave him/her or send him/her away?
☐	**Impaired Caregiver:** Was there ever a time when someone who was supposed to take care of your child couldn't, like they were too sick, they were so sad they stayed in bed, or they had a drinking or drug problem?
☐	**Sexual Assault:** Did someone outside your child's family ever force him/her to do something sexual? Did your child ever see someone else being forced to do something sexual?
☐	**Kidnapping/Abduction:** Has you child ever been stolen or kidnapped (taken somewhere against his/her will) by someone without the permission of his/her parent or legal guardian?
☐	**Bereavement:** Has someone your child cared about ever died?
☐	**Separation:** Was your child ever separated for a long time from someone he/she depends on, like a parent went to jail or was hospitalized, or he/she was placed in foster care?
☐	**War/Political Violence:** Has your child lived in a country where a war or armed conflict was happening (like soldiers or groups were fighting with weapons)? Did he/she see people who had been badly hurt or killed in a war or where soldiers were fighting?
☐	**Forced Displacement:** Has your child ever been forced to move out of his/her house due to war, armed conflict, or disaster, like having to move to a trailer or refugee camp?

☐	**Trafficking/Sexual Exploitation:** Has your child ever done sexual things for money, food, clothes, shelter, or protection? Was he/she ever sold to someone to work for them? Has he/she been forced into having sex (prostitution) or doing sexual thing, like being in sexual pictures (pornography)?
☐	**Bullying:** Has someone your child's age or a student at his/her school ever bullied him/her, like kept calling him/her dirty names, making sexual comments, threating to beat him/her up, or spreading mean rumors around school or online?
☐	**Attempted Suicide:** Has your child ever tried to kill himself/herself?
☐	**Witnessed Suicide:** Has your child ever seen someone after they tried to commit or committed suicide?

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program

Financial Coverage (please complete)

Clients Name: _____ Date of Birth: _____

Social Security Number: _____

1. Is client covered by any private insurance? _____

   Policy holders Name: _____

   Employer: _____

   Insurance company (name/address/phone): _____

   _____

   Policy Number: _____

   I.D. Number: _____

   Group Number: _____

   Claims Address/Phone: _____

   _____

2. Is client covered by **Medicaid**? _____

   Medicaid Number: _____

3. Is client approved for outpatient services? _____

   Carolina Access Doctor's Name: _____

   Doctor's Carolina Access Number: *(Contact PCP to obtain number)*: _____

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
Amos Cottage/United Way
Request for Financial Assistance for Therapeutic Day Program

Client's Name: _____
Parent/Guardian Name: _____
Number of people in immediate family: _____
Home Address: _____
Home Phone Number: _____ Work Phone Number: _____
Immediate family members in client's household:

Name	Relationship to client

List all employers or source of income/Reason for none for 12-month period	Dates from	To	Yearly Gross Income	Yearly Income after Tax	Documented
		Total gross family income			
		Fed, state & SS Tax			
		Income after Taxes:			

Total amount after taxes: _____

Eligibility for other programs *(check all that apply)*
SSI: _____ Medicaid: _____ Medicaid #: _____
Eligibility Date: _____

Please complete the entire form; partial completion of form can delay the admission process

Applicant's signature: _____ Date: _____

Relationship to client: _____

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

WAKE FOREST BAPTIST HEALTH
For a list of entities covered by this form please see
www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

For Office Use Only: MRN: _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: (Primary Care Provider)
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: Amos Cottage Therapeutic Day Program
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway
(Address of authorized recipient of information)

Winston-Salem, NC 27103 (*City/State/Zip*) 336-713-7497 (*Phone Number*) 336-702-9199 (*Fax Number*)

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

- ☐ Emergency Department
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Office/Clinic Note
- ☐ Radiology result
- ☐ Cardiac Catheterization
- ☐ Pathology report
- ☐ Lab result
- ☐ Other specific (please list): _____
- ☐ Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.)

Must provide the **treatment/visit date(s):** ☐ most recent or specific date range ☐ _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose:**

☐ At the request of the individual ☐ treatment ☐ insurance ☐ legal ☐ changing doctors ☐ Other: _____

Requested format: ☐ Electronic Copy ☐ Paper copy ☐ CD ☐ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ☐pickup ☐MyChart (if available, appropriate) ☐ Other: _____

- I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.
- I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department **you specified above.**

To obtain information from another Facility/Practice or Department individual authorizations will be needed.

Please contact the specific department or WFBH HIM Department at (336) 716-3230 with questions.

WAKE FOREST BAPTIST HEALTH
For a list of entities covered by this form please see
www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

For Office Use Only: MRN: _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: _____ (Daycare/School)
(Name of Wake Forest Baptist Health Facility, Practice or Department authorized to use/disclose the information)

(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: Amos Cottage Therapeutic Day Program
(Name of Entity, Person(s) or class of persons authorized to receive the information)

3325 Silas Creek Parkway
(Address of authorized recipient of information)

Winston-Salem, NC 27103 *(City/State/Zip)* 336-713-7497 *Phone Number* 336-702-9199 *Fax Number*

Description of information that may be used/disclosed: *(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)*

Specific records:

- ❑ Emergency Department
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Office/Clinic Note
- ❑ Radiology result
- ❑ Cardiac Catheterization
- ❑ Pathology report
- ❑ Lab result
- ❑ Other specific (please list): _____
- ❑ Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.)

Must provide the **treatment/visit date(s):** ❑ most recent or specific date range ❑ _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose:**

□ At the request of the individual □ treatment □ insurance □ legal □ changing doctors □ Other: _____

Requested format: ❑ Electronic Copy ❑ Paper copy ❑ CD ❑ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ❑pickup ❑MyChart (if available, appropriate) ❑ Other: _____

- I understand that if the person(s) or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.
- I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department **you specified above.**

To obtain information from another Facility/Practice or Department individual authorizations will be needed.

Please contact the specific department or WFBH HIM Department at (336) 716-3230 with questions.

Revised 8/2018

MRROI

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
School Information Request

(To be completed by school or daycare staff)

Child's Name: _____ Student/School number: _____

Dear Teacher:

The parent/guardians of the above-named child are interested in admitting their child to the Therapeutic Day Program at Amos Cottage with Atrium Health Wake Forest Baptist. Your responses to the following questions are an essential component to the evaluation for admission and will be greatly appreciated.

A. Basic Information

1. School name, address, phone: _____
   _____
2. Hours of attendance: _____ Teacher Name: _____
3. Number of students in class: _____ Age Range/Grade: _____
4. Number of adults (teachers, aides, volunteers) available for supervision of these children? _____
5. Does this child have an active IEP in place? _____ (If the child has an IEP the program will need a copy of the plan prior to admission)
6. What concerns do you have of this child at this present time? Please list in order of concern.
   1) _____
   2) _____
   3) _____
   4) _____

Was an IST referral initiated? _____ (Please provide a copy of any referrals made to the IST Team)

For School Age Children, the following documentation/plans will need to be provided to the program to further support admission.

What interventions have been implemented to address the above noted behaviors and found unsuccessful (e.g., **Functional behavioral Assessment, Functional Behavioral Plan, Individualized Education Plan, 504 Plan, Behavior Plans)?** _____

_____

_____

Please provide the program a copy of these interventions verifying implementation along with this document. (Note comments here)

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
School Information Request

(To be completed by school or daycare staff)

For Pre-school age children the program will need documentation detailing specific behavioral interventions that were implemented and found unsuccessful. This documentation is needed to further support admission. These may include interventions suggested by the 'Behavioral Specialist'/Work Family Resource/Smart Start. Please provide the program a copy of these interventions verifying implementation or note the interventions here: _____

_____

_____

What contact have you had with the parents? _____

Has the child received a developmental evaluation? _____

(If yes, who performed the evaluation? _____

Please **check** the areas of **currently concern:**

Gross Motor Skills:

☐Running ☐ Climbing unassisted ☐ Pedaling a tricycle ☐ Jumping with good balance ☐ Using stairs alternating feet ☐ Balancing on one foot ☐ Kicking a ball ☐ Throwing a ball overhead ☐ Sliding unassisted

Fine Motor Skills:

☐ Holding a pencil ☐ Copying (lines/circles) ☐ Using scissors ☐ Opening wrappers

Self-Help Skills:

☐ Using both spoon/fork ☐ Toileting independently ☐ Undressing independently ☐ Dressing independently ☐ Washing/Drying hands independently

Strength and Muscle Tone:

☐ Loses balance ☐ Clumsy ☐ Can't hold sitting position on floor for 5 minutes ☐ Muscles too tight ☐Muscles too loose

Sensitivities:

☐ Avoids certain clothing items ☐ Avoids certain foods/smells ☐Picky eater ☐ Wears clothes incorrectly ☐ Becomes frightened when feet leave the ground ☐ Avoids going barefoot ☐ Bothered by certain noises (specify noise): _____

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
School Information Request

(To be completed by school or daycare staff)

Please **check** the areas of **current concern**:

Seeks Sensation:

☐ Chews clothes ☐ Enjoys/Makes strange noises ☐ Can't sit still/Fidgets ☐ Becomes overly excited during activities ☐ Touches people/objects ☐ Doesn't notice when hands/face are messy

Listening Skills:

☐ Hears what is being said ☐ Difficulty paying attention ☐ Easily distracted by noise in immediate setting

Cognitive Learning:

☐ Understanding positive/negative consequences ☐ Following/understanding rules ☐ Stops and thinks before acting ☐ Learns new concepts ☐ Remembering what they have learned ☐ Distinguishing between reality/fantasy (understands what is real and what is pretend

Attention/Activity level:

☐ Overly Active ☐ Low energy/underactive ☐ Appears in own world ☐ Short attention span

Social/Emotional:

☐ Expressing feelings verbally: ☐ Happy ☐ Sad ☐ Angry ☐ Afraid
☐ Naming/Identifying a friend ☐ Limited range of activities/toys ☐ Odd/Intense interests ☐ Engaging in cooperative play ☐ Engaging in imaginary/pretend play ☐ Little interest in peers ☐ Little interest in adults

Other:

☐ Accepts transitions ☐ Insists on routines ☐ Difficulty separating from family members ☐ Repeats questions when answers are provided ☐ Appears worried ☐ Often complains of not feeling well ☐ Likes things a certain way ☐ Does not like when play items are moved ☐ Speaks less in group settings ☐ Often appears irritable ☐ Mood changes frequently ☐ Unaware of danger ☐ Sleep problems

Comments:

_____
_____
_____
_____
_____

Signature: _____ Date: _____

Title: _____

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
School Behavior Intervention Plan

Program/Facility Name: _____

Child/Student Name: _____

Name/Title of Person Completing Plan Form: _____

Describe Problem Behavior(s):

Problem Behavior (*Aggression, Disrupting Class, Elopement/Running from Room)*	**How Often/Frequency**	**How Long/Duration**	**Data** *(Include collection methods/source dates)*
1.			
2.			
3.			

a) **Antecedent** *(summarize what happens BEFORE each identified behavior)*

___ Lack of Social Attention ___ Demand Request ____ Difficult Task ____ Transition

____ Interruption/Change in Routine _____ Consequences Imposed

____ Other/Describe _____

Brenner Children's
WAKE FOREST BAPTIST HEALTH

Amos Cottage Therapeutic Day Program
School Behavior Intervention Plan

Describe Behavioral Interventions Used: (Proximity to Teacher/Reward Program; Modified – Shortened Day: 1:1 Instruction/Attention…)

_____
_____
_____
_____
_____

Describe Child's Current Response to Interventions Used:

_____
_____
_____
_____
_____

Summary Statement: General Impression of Behavior; why would this child benefit from a therapeutic setting.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Contact Amos Cottage Therapeutic Day Program with any questions regarding the completion of this form: Intake Specialist (336-713-7493 or Program Director (336-713-7443)

Please return completed forms to the TDP Program Assistant (Cindy DiNicolas) by fax (336-702-9199), email (cldinico@wakehealth.edu), or by mail (3325 Silas Creek Parkway, Winston-Salem, NC 27103).