TIDELANDS HEALTH
PEDIATRIC REHABILITATION SERVICES

PEDIATRIC MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name:_____ Date: ___/___/___ Birthdate: ___/___/___ Age: _____

Height: _____ Weight: _____ Referring Physician:_____

Medical History: *(Please check yes/no)*

___ Diabetes ___ Cancer ___ Tuberculosis ___ Visual Impaired
___ Epilepsy ___ HIV / AIDS ___ Hearing Impaired ___ Asthma ___ MRSA
___ Latex Allergy ___ Scoliosis ___ Hepatitis ___ Allergies

___ Food Allergies. Please list:_____

Please list any medications that your child is taking:_____

_____

Please list any diagnostic tests that have been performed for this condition:_____

_____

Has surgery been performed for the condition? Y or N If yes, please give approximate date:_____

What are the current symptoms?_____

When did the injury or symptoms occur?_____

Does your child have pain? If so, where is the pain or problem located?_____

How does your child let you know he/she has pain?_____

Please rate your child's pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine) _____

Have you recently experienced abuse or neglect (physical, emotional, etc.)? Y or N

Do you plan to harm yourself or commit suicide? Y or N (Lifeline number given to caretaker ____ Therapist's initials)

Has your child received a speech therapy evaluation before? Y or N

Is your child being seen by any Home Health Services or Agencies? Y or N

If so, please list:_____

What do you hope to accomplish with therapy?_____

_____

Have you lived in or traveled outside of the United States within the past 14 days? Yes No
If yes, where: _____

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Tidelands Health Pediatric Rehabilitation.

Parent/Guardian Signature:_____

Therapist's Comments:_____

Therapist Signature:_____ Date/Time:_____

TIDELANDS HEALTH

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Patient Name: _____

DOB: _____

Thank you for choosing to be a part of the Tidelands Health family. Our therapists are dedicated to providing you and your child with the best services available. The goal of physical, occupational, and speech therapy is to promote function, educate families, and help integrate your child into the community. Parent participation and education is crucial for your child to progress in therapy. Providing a safe, clean, and calm environment is also important. Below are guidelines enforced by our staff. They will allow your child the opportunity to receive the maximum benefits from therapy. Thank you for your commitment to your child and to achieving better health.

- Regular attendance is important for your child's progress.
- Late arrivals to appointments will reduce the amount of therapy your child receives, which will also negatively affect your child's progress.
- If you are going to be late to therapy, please call the clinic to see if you need to cancel.
- If you arrive 15+ minutes late for an appointment, your child might not be seen that day.
- If you need to cancel your appointment, please call at least 24 hours prior to your appointment.
- A "no-show" occurs when your child misses an appointment without calling the clinic prior to the beginning of the session. If the parent calls during the missed session, the absence is considered a "no-show".
- If you have two "no-shows" within an eight-week period, your child will be discharged from therapy.
- If you cancel *half* of your child's appointments consistently, your child will be discharged from therapy.
- The referring physician will be notified if your child is discharged from therapy.
- Running, climbing on furniture, rough play, food, and drinks are not allowed in the lobby.
- Due to infection control issues, toys will not be provided for siblings to use in the lobby. You are welcome to bring your own toys.
- You must stay in the office with your child until a therapist brings your child back for therapy. You may not drop them off in the parking lot or waiting room. If you leave during your child's appointment, you must leave a current cell phone number so you can be reached if needed.
- Please return to the office five minutes before the end of the therapy session. If you are late to pick up your child one time, you will lose the privilege of leaving the building during therapy.
- Child release policy: In the event your child will be picked up by someone other than yourself, we will need permission. Please list the individuals that you give consent to and provide at least 1 more working phone number in case of scheduling changes etc.
- The goal of our staff is to provide excellent service and care for each patient on an individual basis. In therapy, to assist your child in meeting goals and for safety, palpation and touching is required in assessing, treating, or directing your child during a treatment session.

Parent/Legal guardian: _____ Phone: _____
(Please Print)

Additional family/friends: Relationship: Permission to Consult: Yes/No

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

To ensure patient safety we will be using a photo ID (facial recognition) and name for patient identification. You may bring in a most recent photo of your child that will become the property of Tidelands Health Pediatric Rehabilitation to be put in the patient's chart. Please submit headshots only. If you do not have a photo ID we will be asking name and date of birth as identifiers.

We appreciate your assistance in providing consistent and quality services for your child.

_____ _____ _____ _____

Parent/Caregiver Signature Date Therapist Signature Date/Time

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Conference Consent Form

Patient Name: _____ DOB: _____

Dear Parents and Caregivers:

In an effort to uphold HIPPA regulations and protect the privacy of your child, we ask that you indicate your post-session, preferred location of communication with your therapist. In addition, we ask that you:

- Are available, in the lobby, ten minutes prior to the end of your child's session.
- Temporarily exit the lobby if you are uncomfortable hearing information that other parents have elected to receive in this area.

[CHOOSE ONE]

_____ I elect to receive verbal consult regarding my child's session from the treating therapist in the lobby. The therapist will make every effort to consult in a discreet fashion; however, I understand the potential for others to hear the information being shared.

_____ I elect to enter the treatment area 5-10 minutes prior to the end of my child's session to receive consultation in private. I understand that I am responsible for entering the session and providing adequate time for consult.

_____ _____
Parent/Caregiver Signature Date

_____ _____
Therapist/Witness Date

Revised 10-24-19

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ATTENTION

Illness can be especially dangerous for children with special needs. If a patient, parent, caregiver or sibling has experienced any of the following symptoms, we are kindly asking you to avoid entering our building.

- Fever within the past 24-48 hours
- Vomiting within the past 24-48 hours
- Diarrhea within the past 24-48 hours
- The flu
- Exposure to someone else with vomiting, diarrhea or the flu
- Productive and/or excessive coughing
- Colored nasal discharge

Please be respectful of our children and staff. Please stay at home if anyone in your family or within your immediate contact has any of the symptoms listed above.

Discretion will be left to staff members and therapists with regard to treating children displaying the symptoms listed above.

Please sign acknowledging you have read the above information.

Patient Name: _____ DOB: _____

_____ _____

Signature Date

[redacted]

TIDELANDS HEALTH

About SCHIEx / Notice of Participation

Your doctor or health care provider has become a member of the South Carolina Health Information Exchange ("SCHIEx"). SCHIEx makes it possible for your doctor to share your medical history, including medications, allergies, diagnoses and procedures, with other doctors and health care providers involved in your care. It is a safe and secure network that makes sure your personal health information is available to your doctors and other health care providers when and where it is needed. SCHIEx does *not* keep or store your personal health information. This notice tells you how doctors and other health care providers may use or share your electronic health information and with whom it may be shared.

How your electronic health information may be used or shared

Your privacy and your personal health information are protected by federal and state law. Those federal and state laws also govern the way your personal and electronic health information is used or shared through SCHIEx. Your doctors and other health care providers will use and share your electronic health information with other doctors and health care providers involved in your care through SCHIEx to provide, coordinate or manage your health care and any related services.

We would share your electronic health information, as necessary, through SCHIEx with another doctor who has requested to see your electronic health information to provide care to you. We may share your electronic health information from time-to-time with a doctor or health care provider (i.e. a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by helping with your diagnosis or treatment or with whom you start a new treatment relationship.

Participation in SCHIEX

You may 'opt out' of SCHIEx participation. By opting out , your personal health information will not be shared through SCHIEx.

Important information: Please understand that if you opt out, your personal health information will not be used or shared by **any** doctor or healthcare provider through SCHIEx, except where required by law, which could create a delay in your healthcare provider receiving necessary information for your care.

If you change your mind and wish to have your electronic health information shared through SCHIEx, you may cancel your opt out. To cancel your opt out, you or your personal representative must inform hospital registration staff.