PEDIATRIC AUDIOLOGY POLICIES

Patient
Label

(256) 265-7952 phone
(256) 265-7953 fax

Supervision: An adult must accompany all children to their appointments. **If a child is under 14 years old or has developmental delays, an adult must remain on the premises during the child's appointment.** Our staff may ask a parent to stay for other reasons at their discretion.

A **parent or legal guardian** must be present to sign consent for testing/treatment on the patient's initial visit. We cannot provide testing or treatment without legal consent.

Siblings: While siblings may attend sessions, it is not recommended. If siblings do attend sessions, they must either be able to sit quietly during testing or wait in the reception area *with an adult.* If the audiologist's attention cannot remain focused on the child being tested or quiet test conditions cannot be maintained, testing may need to be rescheduled. Again, please remember that all children must be supervised by an adult at all times.

Tardiness: Every effort is made to see patients in a timely manner. You can help. Please arrive in time to complete the registration process and begin testing at your child's appointment time. Patients arriving more than 10 minutes after their appointment will be seen only if the audiologist's schedule permits. Rescheduling may be required.

Cancellations: We understand that, from time to time, there will be reasons you must cancel your appointments (illness, car trouble, out of town, etc.). We ask that you call our office as soon as possible so we may accommodate other patients. **A call less than an hour prior to your appointment time will be counted as a "no show."**

No Shows: Should you fail to show for a scheduled appointment, it will be documented in your child's chart and a letter may be sent to your child's physician.

Scheduling Holds: "No shows" and excessive tardiness or cancellations can negatively impact not only your child's care, but also the care of other children. Therefore, patients will be placed on a scheduling hold for 6 months if they (a) fail to show for 2 consecutive appointments or (b) have a total of 3 "no shows," late arrivals, or cancellations in any combination over a 6-month period. A letter will be sent to your child's physician, notifying them of this action. Additional appointments will not be scheduled for your child until the scheduling hold has expired. This policy is necessary to best serve all patients in need of audiologic care.

Inclement weather: Pediatric Audiology follows Huntsville City Schools closings and delayed openings for inclement weather. If they close or open late due to weather, we will do the same. This is for **WEATHER ONLY**.

Insurance Coverage: Please call your insurance carrier. Some insurance carriers require prior authorization and/or pre-admission certification for audiology testing and procedures. If this is required and not done, they can refuse to pay for services. Some insurance carriers may have a limited amount of, or no, coverage for audiology procedures or hearing devices. You will be responsible for payment for services not covered by your insurance.

I have read and understand the above policies.

____________________ ____________________
Patient's Representative Date

____________________ ____________________
Audiologist Date/Time

Women & Children
HUNTSVILLE HOSPITAL

PEDIATRIC THERAPY & AUDIOLOGY CASE HISTORY FORM

Child's Name: ______________________ **Date of Birth:** ______________ **Age:** ____________

Preferred Name or Nickname: ______________________ ( ) Male ( ) Female

Referring Physician: ______________________ **Services Requested:** ( ) PT ( ) OT ( ) ST ( ) Audiology

Diagnosis ____

Is your child currently receiving therapy services? ( ) Yes ( ) No **What Type?** ( ) PT ( ) OT ( ) ST

If yes, where are they receiving therapy? ____

Family Information

With whom does the child live? (provide names) ______________________________

Parents/Guardian phone numbers______________________________

Home Address ______________________________

Does he/she have brother and sisters? ( ) Yes ( ) No Age of sibling(s):______________

Medical History

Type of Delivery: ( ) Vaginal Delivery ( ) C-section ( ) Vacuum ( ) Forceps

Length of pregnancy ( ) Full term, __________weeks ( ) Pre-term, __________weeks

Any complications or infections (for example: CMV, herpes, rubella, syphilis, toxoplasmosis) during pregnancy or delivery? ______________________________

____

Following birth, did the baby have difficulty, require extended hospitalization, special testing, or surgery?

____

____

Since birth, has the child been hospitalized or had surgery? ( ) Yes ( ) No

If yes, please list age at time of admission and reason for admission and any surgery done:

Date	Reason for Hospitalization	Surgery

Patient Label

AUDITK

Has your child ever been diagnosed with any of the following conditions?

( ) Cleft lip ( ) Cleft Palate ( ) Both cleft lip and cleft palate
( ) Hydrocephaly ( ) Microcephaly ( ) Macrocephaly
( ) Encephalitis ( ) Meningitis ( ) Cytomegalovirus (CMV)
( ) Contagious Diseases (Please include common childhood diseases) ____________
( ) Asthma ( ) Sinus/Allergies: If yes, specify: ____________
( ) Other Respiratory problems: If yes, specify: ____________
( ) Cerebrovascular accident (Stroke) ( ) Cerebral Palsy: If yes, Type: ____________
( ) Spina Bifida ( ) Autism/PDD____________ ( )Attention Deficit
( ) Cardiac (heart) problems: Specify: ____________
( ) Pacemaker ( ) Defibrillator
( ) Failure to Thrive ( ) Gastrointestinal problems (ex: Reflux) Specify: ____________
( ) Cancer: Specify: ____________
( ) Diabetes ( ) Blood disorder ____________
( ) Genetic Syndrome: If yes, specify: ____________
( ) Orthopedic injuries (ex: broken bones) Specify: ____________
( ) Joint Condition/Arthritis ( ) Torticollis ( ) Skin Condition ____________
( ) Pregnant ( ) Lactating
( ) Other____________

Has your child ever experienced seizures? ( ) Yes ( ) No If yes, when was the last time? ____________

Is your child on medication for the seizures? ( ) Yes ( ) No

Has your child ever had special testing done for the seizures? ( ) Yes ( ) No

If yes, what testing was done? ____________

What were the results of the testing? ____________

Developmental History

At what age did your child:

Sit with assistance? ____________
Crawl? ____________
Cruise furniture? ____________
Hold items with two hands? ____________
Reach to get what they want? ____________
Babble? (ex. Baba, awaba, etc.)____________
Say first word? ____________

First roll over? ____________
Sit alone? ____________
Pull to Stand? ____________
Walk? ____________
Pick things up? ____________
Use of variety of sounds in play? ____________
Combine words? ____________

Is your child toilet trained? ( ) Yes ( ) No If yes, at what age: ____________

Please list your child's favorite toys ____________

Feeding/Swallowing

Is/was your child: ( ) Breast fed ( ) Bottle fed ( ) Both For how long? ____________

What kind of diet is your child currently on? ____________

Does your child feed him/herself? ( ) Yes ( ) No Eat with assistance ( ) Yes ( ) No

Does your child have any suspected swallowing problems? ( ) Yes ( ) No

Does your child have any known swallowing problems? ( ) Yes ( ) No

Is he/she fed by alternative feeding, methods? (G-tube, Ng tube) ( ) Yes ( ) No

If yes, please specify ____________

Has your child experienced recent weight gain? ( ) Yes ( ) No OR weight loss? ( ) Yes ( ) No

Does your child require skilled nursing care in the home? ( ) Yes ( ) No

Patient
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AUDITK

Does your child have any vision problems? ( ) Yes ( ) No

If yes, please clarify: ______________________________

Hearing History

Do you have any concerns about your child's hearing? ( ) Yes ( ) No

If yes, please explain: ______________________________

Is there a family history of hearing loss? ( ) Yes ( ) No

If yes, please explain: ______________________________

Does your child have a history of acute or chronic otitis media (ear infections)? ( ) Yes ( ) No

If yes, has your child ever had "tubes"? ( ) Yes ( ) No

If yes, how old was your child when they were placed? ______________________________

Has your child's hearing been screened or tested before? ( ) Yes ( ) No

If yes, when was the testing completed and what were the results? ______________________________

____

If treatment or follow-up was recommended, please describe: ______________________________

____

Communication Needs

Do you or your child have any special communication needs?

Child: ______________________________

Caregiver: ______________________________

What is your preferred language?

Child: ______________ Caregiver: ______________

Learning Profile

Do you or your child have any barriers to learning? (ex. Visual, hearing, language, or mental impairments?)

Child: ______________________________

Caregiver: ______________________________

How do you feel your child learns best? ( ) visualization ( ) verbal instruction ( ) demonstration

How does caregiver learn best? ( ) visualization ( ) verbal instruction ( ) demonstration

Does your child attend school or daycare? If so, what type and are there any special services provided?

____

Does the child or caregiver have any limitations in mobility (ex. Use a wheelchair, crutches, or have difficulty moving?)

Child: ______________________________

Caregiver: ______________________________

Family Goal for Evaluation/Treatment: ______________________________

____

Person completing Form: ______________ **Relationship to Child:** ______________

Signed: ______________ **Date:** ______________

Information reviewed and verified by clinician______________________________

Clinician signature/date/time

Patient Label

Women & Children
HUNTSVILLE HOSPITAL

PEDIATRIC THERAPY AND AUDIOLOGY MEDICATIONS AND ALLERGIES

Patient's Name: ______________________ **Date of Birth:** ______________ **Age:** ____________

Current Medications:

Medication Name	Dose	Route (by mouth, etc)	How often	Reason

Does your child have any allergies? ( ) yes ( ) no

If returning patient, are there any new allergies? ( ) yes ( ) no

Allergy	Reaction	Severity (mild, moderate, critical, unknown)
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown
		( ) mild ( ) moderate ( ) critical ( ) unknown

Person completing Form: ______________________ **Relationship to Patient:** ______________________

Signed: ______________________________ **Date:** ______________________

Information reviewed and verified by clinician: ______________________________

Clinician signature/date/time

Patient
Label

AUDITK