



UCLA Pediatric Rehabilitation Parent Questionnaire

Contact Information

Child's Preferred Name or Nick Name: _____ Date: _____

Name of Parent(s): _____ Home Phone: _____
Mother/Guardian *Father/Guardian*

Contact Numbers: _____
Cell Phone 1 *Cell Phone 2* *Work Phone*

Concerns and Goals

What are your main concerns about your child? _____

What are your goals for physical therapy? _____

Birth and Medical History

Gestational Age: _____ weeks Birth Weight: _____

Please check all that apply:

- Baby was full term premature spent time in intensive care
- Delivery was vaginal a planned c-section an emergency c-section
- breech required suction required forceps
- Child is a twin or part of a multiple birth

Were there any complications of the pregnancy or birth? If yes, please describe.

Has your child ever had any of the following? Please check those that apply.

- Heart Problems Stomach Problems/Reflux Rash/Skin Problems
- Cancer Seizures Dislike of certain textures/food
- Broken Bones Breathing Problems Difficulty eating or swallowing
- Brain Injuries Ear Infections/Other Infections Difficulty following instructions
- Sadness or hopelessness Attempts to harm self or others

Is your child taking any medications? Yes No If yes, please list all medications.

Name of Medication	Dosage	Frequency
1.		
2.		
3.		

Please turn page over and continue

PATIENT EDUCATION ASSESSMENT

Date: _____

In order to help us in meeting your education needs, please take the time to answer the questions below.

Person completing the form: Patient Family Significant Other
 Healthcare Professional

1. Is English your primary language? Yes No

Do you have another language in which it is easier for you to communicate? Preferred language: _____ Yes No

2. Do you have any problems with your vision or hearing that might affect how we teach you? If yes, please explain: Yes No

3. How would you prefer to receive information regarding your care? (Check all that apply): Written Verbal Demonstrate
 Other: _____

4. Do you have any beliefs or practices that might affect how we teach you? If yes, please explain (such as religious, cultural, or spiritual): Yes No

5. Are you ready to receive health instruction? If no, please explain: Yes No

6. Comments: _____

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WELCOME!

Welcome to UCLA Outpatient Rehabilitation Services. We are pleased that you and your physician have chosen UCLA to meet your rehabilitation needs. Your primary therapist is _____, and your first appointment is _____.

We offer a team approach, involving the primary therapist and other skilled staff members. Your primary therapist will coordinate your care, and you may be seen by other team members for the best possible outcome.

Your involvement in this treatment process is important! Your therapist will evaluate you and design a program to address your specific problems. After evaluation, you, your therapist and your physician will determine the number of visits needed to reach your goals. The goals and number of visits needed to achieve them will be reviewed with you on a regular basis and may change from the number initially set. Regular attendance and following the exercises and recommendations of your therapist will help you achieve your goals.

PAYMENTS

You are responsible for services not covered by your insurance. Some carriers require co-payments be paid each visit. For those patients with a deductible and coinsurance, Patient Business Services will bill your insurance first and then bill you if there is a remaining balance. Patients without insurance coverage will be asked for payment at the time services are rendered.

SPLINTS/DEVICES

If you receive a splint, orthotic or prosthetic device and are having fitting problems, please contact us. Some circumstances may require a return visit to your physician.

PARKING

Pay-by-Space metered self-parking is available in the Lot 32, near our building. For your convenience, valet parking is also available, and rates are posted.

SCHEDULING

Prior to scheduling your first visit, we must have a signed physician order in the department. The therapist will determine the number of visits, the length of the visits and with whom to schedule your appointments.

If you must cancel or change an appointment, please contact us at least 24 hours prior to the scheduled time.

Cancellations within 24 hours of the appointment may result in a late cancellation fee.

If your insurance is Medicare, your physician will be required to submit a request for continued care every 30-90 calendar days. Without this new prescription from your physician, you will be discharged from therapy.

Other reasons to be discharged from therapy include the following:

- Lack of current order
- By order of your physician
- "No showing" for an appointment and not contacting us within two working days.
- By missing two scheduled appointments without valid reason
- Gap in attendance of more than 30 days
- Intervening acute medical problem or surgery
- Inability to participate in therapy
- Lack of measurable and sustainable goals
- Attaining treatment goals
- Insurance company fails to authorize additional treatments

MEDICAL RECORDS

If you would like a copy of your treatment notes, you must provide a written request. Request should be addressed to:

UCLA Medical Correspondence
10833 Le Conte Ave., Room BH-225
Los Angeles, CA 90095-1677
(310) 825-6021 Telephone
(310) 825-3356 Fax

There may be a charge for providing this record.