

**Please complete the attached form in its entirety and mail to:
Division of Developmental and Behavioral Pediatrics/Thomas Center
Cincinnati Children's Hospital Medical Center
MLC 4002, 3333 Burnet Avenue
Cincinnati, Ohio 45229-3039
Fax number 513-636-0527**

**The Thomas Center for Down syndrome
Intake Form**

Identifying Information

Patient's Name: _____ Date: _____
Birthdate: _____ Age: _____ Sex: _____ MR#: _____
Address: _____
County: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email address: _____
Father: _____ Age: _____ Occupation: _____
Mother: _____ Age: _____ Occupation: _____
Others living in household and ages: _____

Physician Information:

Child's primary care physician: _____
Address (street name): _____
Phone number: _____

School Information

School District: _____ Name of school: _____
Special Services: _____

_____ Dr. Summar
Appointments scheduled with: _____ Dr. Hickey _____ Katie _____ Jennifer
_____ Dr. Mattheis

Date: Mon. _____ ___ Gretchen ___ Stacey
Tues: _____

Patient wants to see Doctor Only _____

Medical Information

Pertinent medical history including other diagnoses and surgeries: _____

Where there any medical problems at birth? Was the child in the NICU?

Has the child had a recent hearing test: _____

Has the child had a recent vision test: _____

Does your child use any assistive devices or special equipment on a daily basis (i.e. glasses, hearing aid, augmentative communication device) ___ Yes ___ No

If yes, please describe: _____

Therapeutic Interventions

Has your child received OT? Y N Dates: _____

Where? _____

Has your child received Speech Therapy? Y N Dates: _____

Where? _____

Has your child received PT? Y N Dates: _____

Where? _____

Other services: _____ Dates: _____

Where? _____

Other services: _____ Dates: _____

Where? _____

Are there any behavior concerns at this time?

Please list any other pertinent therapeutic information:

Additional Information/Comments

What are your main concerns for your child? (If school is an issue Gretchen needs MFE and IEP either faxed or mailed)

1. _____
2. _____
3. _____

Review of systems (these are the questions Dr. Summar asks all patients to be sure that we discuss all of the parental concerns)

	YES	NO
Constitutional:		
Any concerns about weight?	_____	_____
Any concerns about height?	_____	_____
Any unexplained fevers lasting more than 1 week?	_____	_____
Any increased appetite?	_____	_____
Any decreased appetite?	_____	_____
HEENT:		
Any hearing concerns?	_____	_____
Last hearing test? _____		
Any vision concerns?	_____	_____
Last vision test? _____		
Any unexplained lumps in neck?	_____	_____
Any concern about large tonsils?	_____	_____
Any neck pain?	_____	_____
LUNGS:		
Any cough lasting more than 3 weeks?	_____	_____
Any unexplained chest pain?	_____	_____

YES NO

CV:

Any unusual shortness of breath? _____
Any blue spells or cyanosis? _____
Any fainting spells? _____

GI:

Any heartburn? _____
Any frequent vomiting? _____
Extremely bad breath, especially in the morning? _____
Any constipation? _____
Any diarrhea lasting more than 1 week? _____
Any blood in stools? _____
Toilet trained to stooling? _____

GU:

Toilet trained to urination? _____
Pain on urination? _____
Blood in urine? _____
Girls age of menarche? _____
Painful menses? _____
Heavy menses? _____

MS:

Any painful joints? _____
Any swollen joints? _____
Any back pain? _____
Any neck pain? _____

SKIN:

Any concerning rashes? _____
Any concerning birthmarks? _____

Neuro:

Any seizures? _____

Behavior:

Any severe behavior concerns? _____

Development:

Are you concerned about any particular aspect of your child's development? _____

Do you have SSI? _____

Medicaid Waiver? _____