

UNITED CEREBRAL PALSY
Iris S. & Bert L. Wolstein Center
10011 Euclid Avenue
Cleveland, OH 44106
216.791.8363

The children's participation in the Children's Services REQUIRES physical therapy, occupational therapy, and speech & language therapy orders. Upon request this prescription will be sent to the family's insurance company. Please complete the following:

PHYSICIAN'S ORDERS

CHILD'S NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ TELEPHONE: _____

DIAGNOSIS: _____ ICD-9 CODE: _____

DIAGNOSIS: _____ ICD-9 CODE: _____

DIAGNOSIS: _____ ICD-9 CODE: _____

PHYSICAL THERAPY:

_____ EVALUATE & TREAT AS NEEDED

_____ SPECIFIC THERAPY ORDERS: _____

OCCUPATIONAL THERAPY:

_____ EVALUATE AND TREAT AS NEEDED

_____ SPECIFIC THERAPY ORDERS: _____

SPEECH AND LANGUAGE THERAPY:

_____ EVALUATE AND TREAT AS NEEDED

_____ SPECIFIC THERAPY ORDERS: _____

THERAPY PRECAUTIONS/CONTRAINDICATIONS: _____

PRINT PHYSICIAN'S NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP _____ PHONE NUMBER _____

PHYSICIAN'S SIGNATURE: _____ LICENSE # _____

DATE: _____

PLEASE FAX THIS BACK TO CHILDREN'S SERVICES AT 216-791-2539

UNITED CEREBRAL PALSY

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Cleveland, OH 44106-4701

216.791.8363

PHYSICAL EXAMINATION/IMMUNIZATION RECORD

To be completed by physician:

I have examined _____, _____
(Name of Child) (age)
_____ and certify that the child is free from communicable disease, including
(date) tuberculosis, and is in good health or s/he has had the following diseases: (Please check)

Chicken Pox _____ Mumps _____ Herpes _____ HIV _____
Scarlet Fever _____ Whooping Cough _____ Hepatitis _____ Polio _____
German Measles _____ Measles _____ CMV _____ Other _____

He/she has had the following immunizations:

<u>MUST BE COMPLETED</u>	<u>DATES OF SERIES</u>	<u>DATE OF MOST RECENT BOOSTER*</u>
DPT (Series of 4)	_____	_____
Polio (Series of 3)	_____	_____
MMR	_____	_____
TB Test (recommended yearly; one test must be on file)	_____	_____
HIB	_____	_____

* If booster is needed, it should be given now.

If physician does not approve of any one of the immunizations, this should be so indicated on the appropriate line.

Any Precautions: _____

Date: _____ Physician's Signature: _____

Print Physician's Name: _____

Address: _____

City: _____

Zip: _____ Phone Number: _____

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MEDICAL REPORT

_____ Initial: Complete Entire Form

_____ Renewal: Indicate new (within the past year) information, including current medications and shot record.

NAME: _____ SEX: _____ BIRTHDATE: _____

ADDRESS: _____ TELEPHONE: _____

CITY: _____ STATE: _____ ZIP: _____

DIAGNOSIS: 1. _____ ICD-9 CODE: _____

2. _____ ICD-9 CODE: _____

3. _____ ICD-9 CODE: _____

BIRTH HISTORY: _____

HOSPITALIZATIONS - DATES & REASONS: _____

IMPRESSION OF MENTAL FUNCTIONING: _____

DATES & RESULTS OF TESTING: _____

VISUAL IMPAIRMENT: _____

DATES & RESULTS OF TESTING: _____

AUDITORY IMPAIRMENT: _____

DATES & RESULTS OF TESTING: _____

SEIZURES: _____ TYPE: _____ FREQUENCY: _____

MEDICATIONS: _____

ADDITIONAL PERTINENT MEDICAL INFORMATION:

(OVER)

United Cerebral Palsy of Greater Cleveland, Inc.

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

DATE: _____

Legal name: First _____ MI _____ Last _____

Preferred name (nickname): First _____ MI _____ Last _____

Date of Birth _____

Mailing Address _____ Physical Address _____

City/State/Zip _____ City/State/Zip _____

County _____

Township _____

Home Phone _____ OK to Call Best Time to Call _____

Work Phone _____ _____

Cell Phone _____ _____

Email Address _____

Patient's Social Security # _____ Gender: Male Female

Marital Status

- Single Divorced
 Married Widowed
 Separated Unknown

Student Status

- Full-Time
 Part-Time
 None

Employment Status

- Full-Time None, Disabled
 Part-Time Student Unknown
 Active Duty Retired Self Employed

PARENT INFORMATION

Mother Preferred Contact Patient Lives with Mother
 Name _____ Employer _____
 Address _____ Address _____
 City/State/Zip _____ City/State/Zip _____

Home Phone _____ OK to Call Best Time to Call _____

Work Phone _____ _____

Cell Phone _____ _____

Parenting Status: Natural Adoptive Foster Other: _____

Father Preferred Contact Patient Lives with Father
 Name _____ Employer _____
 Address _____ Address _____
 City/State/Zip _____ City/State/Zip _____

Home Phone _____ OK to Call Best Time to Call _____

Work Phone _____ _____

Cell Phone _____ _____

Parenting Status: Natural Adoptive Foster Other: _____

United Cerebral Palsy of Greater Cleveland, Inc.
PATIENT REGISTRATION FORM

INSURANCE INFORMATION

Primary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligible From _____

Insured / Subscriber Information:

Relationship Self Spouse Child Other: Insured / Subscriber Employer:

Name _____ Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone Number _____ Phone Number _____

Date of Birth _____ Sex: Male Female

Contact / Case Mgr: _____ Phone Number _____

Is a referral / authorization required? Yes No (If yes, attach copy)

Secondary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligible From _____

Insured / Subscriber Information:

Relationship Self Spouse Child Other: Insured / Subscriber Employer:

Name _____ Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone Number _____ Phone Number _____

Date of Birth _____ Sex: Male Female

Contact / Case Mgr: _____ Phone Number _____

Is a referral / authorization required? Yes No (If yes, attach copy)

Tertiary Insurance (attach copy of insurance card):

Ins. Co. Name _____ Eligible From _____

Insured / Subscriber Information:

Relationship Self Spouse Child Other: Insured / Subscriber Employer:

Name _____ Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone Number _____ Phone Number _____

Date of Birth _____ Sex: Male Female

Contact / Case Mgr: _____ Phone Number _____

Is a referral / authorization required? Yes No (If yes, attach copy)

Patient Responsibility (amounts not covered by insurance):

Name _____ Date of Birth _____

Address _____ Sex: Male Female

City/State/Zip _____ SSN: _____

Phone Number _____

United Cerebral Palsy of Greater Cleveland, Inc.
PATIENT REGISTRATION FORM

SERVICES TO BE PROVIDED

Type of Service Requested:

Physical Therapy Occupational Therapy Speech / Language Therapy Nutrition

Assistive Tech Audiology Other Services: _____

Reason for Initial Visit: _____

How did you hear about us?

Physician Name _____ Phone _____ Friend
 Advertisement Where _____ Insurance Company
 Internet
 Other: _____

Are you requesting services for injuries resulting from an accident?

Work Auto Other None

PRESCRIPTION INFORMATION – Please attach a copy of your prescription

ADDITIONAL CONTACTS

Legal Guardian (if not parent):

Name _____
Address _____
City/State/Zip _____

	<u>OK to Call</u>	<u>Best Time to Call</u>
Home Phone _____	<input type="checkbox"/>	_____
Work Phone _____	<input type="checkbox"/>	_____
Cell Phone _____	<input type="checkbox"/>	_____

Pediatrician / Primary Care Physician:

Name _____
Address _____
City/State/Zip _____

	<u>OK to Call</u>	<u>Best Time to Call</u>
Home Phone _____	<input type="checkbox"/>	_____
Work Phone _____	<input type="checkbox"/>	_____
Cell Phone _____	<input type="checkbox"/>	_____

Emergency Contact: Relationship: _____

Name _____
Address _____
City/State/Zip _____

	<u>OK to Call</u>	<u>Best Time to Call</u>
Home Phone _____	<input type="checkbox"/>	_____
Work Phone _____	<input type="checkbox"/>	_____
Cell Phone _____	<input type="checkbox"/>	_____

United Cerebral Palsy of Greater Cleveland, Inc.
PATIENT REGISTRATION FORM

ADDITIONAL INFORMATION - (Providing this information is optional but it is essential in helping us apply for grants to fund our services for families who cannot afford it. This information is confidential and will not be disclosed on an individual basis but will only be used to provide consolidated information to organizations that can provide funding for our services.)

Other: White, non-Hispanic Asian / Pacific Islander
 Black, non-Hispanic American Indian / Alaskan Native
 Hispanic Other: _____

Do you speak English? Yes No

Do you understand English? Yes No

Do you require an interpreter? Yes No

If so, what language? _____

School District where patient attends: _____

Household Income: Less than \$10,000 \$40,000 - \$50,000 \$80,000 - \$90,000
 \$10,000 - \$20,000 \$50,000 - \$60,000 \$90,000 - \$100,000
 \$20,000 - \$30,000 \$60,000 - \$70,000 Over \$100,000
 \$30,000 - \$40,000 \$70,000 - \$80,000

Number of People in Household: _____

Female Head of Household: Yes No