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Welcome Letter

Greetings,

Welcome to our integrated medical home!

You are receiving this packet because you or your physician have concerns regarding your child's behavior or emotional wellbeing and have scheduled an appointment for further assessment.

The assessment will be with your child's primary provider at Reading Pediatrics. ***For the best care, all follow-up visits related to behavioral health will be scheduled with the same provider. All concerns or questions related to behavioral health or medication adjustments will be directed to this provider.***

Reading Pediatrics also has a designated behavioral health team of two nurse practitioners, supervised by a licensed psychiatrist, and a licensed social worker. After the initial assessment, some children will be referred to this team for a more comprehensive assessment. The goal of this team is to diagnose and stabilize more complex cases before they are returned to the care of their primary provider.

Prior to your visit, please review and complete the enclosed forms. These forms are necessary to move forward with the evaluation process. Please complete and return to the office in advance. These may be returned by mail, in person at any of our locations, or electronically through the patient portal. If you do not have completed paperwork, your visit may be rescheduled.

If your child has already been evaluated by school, a psychologist, or therapist, kindly bring any testing or correspondence with you for review by the physician. Let our office know if we need to request records from previous providers and specialists and sign the enclosed release of information.

We look forward to working with you!

The Providers of Reading Pediatrics

40 Berkshire Court, Suite 1 • Wyomissing, PA 19610 25 Lorane Road • Reading, PA 19606
5101 Allentown Pike • Temple, PA 19560 541 West Penn Avenue • Robesonia, PA 19551
610-374-7400 • www.readingpediatrics.com

Does My Teen Need Help?

Physical Warning Signs:

- Cuts on arms or legs or other physical signs of self-harm
- Rapid or major weight loss or weight gain
- Physical injuries without good explanations
- Many stomach, head, and/or back aches
- Worsening of a chronic condition

Behavioral or Emotional Warning Signs:

- Major change in eating and/or sleeping habits
- Signs of frustration, stress, or anger
- Unusual or increasing fear, anxiety, or worry
- Relationship difficulties with family, friends, classmates, or teachers
- Skipping school, not participating in class, and/or a drop in grades
- Changes or problems with energy level or concentration
- Sudden mood swings
- Feeling down, hopeless, worthless, or guilty
- Aggressive or violent behavior
- Sudden loss of self confidence or sense of security
- Risky behaviors, breaking laws, stealing, hurting people
- Signs of alcohol or drug use
- Losing interest in things that were once enjoyed
- Constant concern about physical appearance or decrease in personal hygiene
- Isolation from others and often spends time alone
- Secretive about activities and whereabouts

If you notice any of the above warning signs, talk with your teen and then call your teen's health care provider. Be ready to discuss how serious the problem is, when the problem started, and any changes in your teen's school or family situation. Don't wait too long before seeking help.

IMPORTANT QUESTIONS TO ASK YOUR TEEN

- ☑ When and why did this problem start?
- ☑ How much is this problem troubling you?
- ☑ Is the problem getting in the way of your school work or relationships with friends or family members?
- ☑ Have you been having any thoughts about dying or hurting yourself?
- ☑ How can I help you?

Don't be afraid to ask your teen what's going on in his/her life. It will not cause any harm. A teenager in trouble needs support from caring parents.

MENTAL HEALTH EMERGENCIES

- Losing touch with reality
- In great danger of harming him/herself
- In great danger of harming others

If your teen is having an emergency, take her/him to the nearest hospital emergency room or call 911.

***DO NOT** leave her/him alone or unattended. Remove all dangerous items (guns, knives, pills) from your teen's reach.*

Do you have any comments or questions about this handout? Please contact Adolescent Health Working Group by emailing feedback@ahwg.net or calling (415) 554-8429. Thank you.

Sources:
1) Goodman RF. Choosing a Mental Health Professional for Your Child. New York University Child Study Center. 2000, http://www.aboutourkids.org
2) Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. Child and Adolescent Mental Health. 2003, http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp

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Mental Health Crisis Contacts (effective 06/06/22):

Berks County:
Holcomb Crisis Intervention of Berks County: 610-379-2007 or 1-888-219-3910

Chester County:
Valley Creek Crisis Center: 877-918-2100

Lancaster County:
Lancaster County Crisis Intervention: 717-394-2631

Lebanon County:
Lebanon County Crisis Intervention: 717-274-3363

Montgomery County:
Montgomery County Emergency Services Inc.-Crisis Intervention: 610-279-6100

Schuylkill County:
Schuylkill County- Crisis/Emergency Services: 877-993-4357

Please visit the following website for Crisis Intervention in other PA Counties:
https://www.cor.pa.gov/Documents/PA%20County%20Crisis%20Contacts.pdf

ruOKBerks? is a texting option for individuals experiencing suicidal ideations offered via Berks County Suicide Prevention Task Force. Individuals should text 484-816-RUOK (7865).

My Child is in Crisis and is Having Suicidal Thoughts.
What Should I do?

You are not alone. This is a difficult time for a family. Children struggle with emotions that they don't know how to handle and parents oftentimes feel helpless when they can't fix the situation for their children. When one child is in crisis, it impacts the entire family.

The following is a general Safety/Crisis Protocol to be implemented to assure your child's safety:

Safety Planning Protocol:

Please be sure to secure:

1. All sharp objects (kitchen/pocketknives, scissors, razors)
2. Medications (over the counter (OTC) or prescription)
    a. Medications should be dispensed by an adult on a daily/per time basis
    b. Medications can either be placed into weekly pill organizers if agreed to by provider
3. Any lethal weapons (arrows/guns/rope)

Patient and parent must agree:

1. That patient will share with an adult when experiencing suicidal ideations.
    a. Communication can be verbal or non-verbal
    b. Code words designed to communicate that the patient doesn't feel safe or is having negative self-thoughts often work well in these situations
2. Adults can offer to listen if patient wants to talk, but do not force the patient to talk as this often exacerbates the negative feelings.
3. Please be supportive and validate your child's feelings…It must be hard to feel …, is there anything that I can do to help? We're family, we will get through this together…
4. Be cautious to refrain from telling your child that they have so many things to be thankful for or their feelings don't make sense.
5. Patient will be supervised 1:1 by an adult while these feelings continue
    a. An adult will be in eyesight of patient at all times
    b. Patient agrees to leave bathroom door open when in use
    c. Parent may have to sleep in the same room as patient.
6. Patient will be encouraged to engage in activities including, but not limited to:
    a. Journaling
    b. Arts/crafts
    c. Listening to upbeat music
    d. Watching humorous television shows/movies
    e. Go for drive outside the home
    f. Puzzles

If the patient attends therapy, please contact the therapist to discuss increasing the frequency of sessions.
If the patient receives medication management services, please speak to a provider/representative to discuss whether an adjustment is needed.

If the patient is not prescribed medication, please schedule an appointment with the patient's primary care provider to discuss whether medication may be helpful.

We recognize and respect the level of severity mental health crises present. Please try to be patient. Unfortunately, most mental health medications do take time to become effective.

If your child's feelings continue for a 24 hour period of time or he/she expresses suicidal ideations with an active plan and/or intent please:

1. Call your county's crisis center (see list below)
2. Go to the nearest emergency room
3. Call 911

I agree to follow the above stated safety protocol:

____ ______________________

Patient Date

____ ______________________

Parent/Guardian Date

Crisis Contacts:

Berks County:
Holcomb Crisis Intervention of Berks County: 610-379-2007 or 1-888-219-3910
Chester County:
Valley Creek Crisis Center: 877-918-2100
Lancaster County:
Lancaster County Crisis Intervention: 717-394-2631
Lebanon County:
Lebanon County Crisis Intervention: 717-274-3363
Montgomery County:
Montgomery County Emergency Services Inc.-Crisis Intervention: 610-279-6100
Schuylkill County:
Schuylkill County- Crisis/Emergency Services: 877-993-4357

Please visit the following website for Crisis Intervention in other PA Counties:
https://www.cor.pa.gov/Documents/PA%20County%20Crisis%20Contacts.pdf

ruOKBerks? is a texting option for individuals experiencing suicidal ideations offered via Berks County Suicide Prevention Task Force. Individuals should text 484-816-RUOK (7865)

To be filled out by patient (Ages 8-18). Allow older children privacy when answering these questions. (2 pages)

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ______________________________ Date: ______________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you *for the last 3 months*.

	0 Not True or Hardly Ever True	**1** Somewhat True or Sometimes True	**2** Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 2 of 2 (to be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	GD
22. When I get frightened, I sweat a lot.	O	O	O	PN
23. I am a worrier.	O	O	O	GD
24. I get really frightened for no reason at all.	O	O	O	PN
25. I am afraid to be alone in the house.	O	O	O	SP
26. It is hard for me to talk with people I don't know well.	O	O	O	SC
27. When I get frightened, I feel like I am choking.	O	O	O	PN
28. People tell me that I worry too much.	O	O	O	GD
29. I don't like to be away from my family.	O	O	O	SP
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	PN
31. I worry that something bad might happen to my parents.	O	O	O	SP
32. I feel shy with people I don't know well.	O	O	O	SC
33. I worry about what is going to happen in the future.	O	O	O	GD
34. When I get frightened, I feel like throwing up.	O	O	O	PN
35. I worry about how well I do things.	O	O	O	GD
36. I am scared to go to school.	O	O	O	SH
37. I worry about things that have already happened.	O	O	O	GD
38. When I get frightened, I feel dizzy.	O	O	O	PN
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	SC
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	SC
41. I am shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.
"

To be filled out by one or both parents/guardians. You may print multiple copies if multiple households. (2 pages)

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

Name: ____ Date: ___________________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 **Not True or Hardly Ever True**	1 **Somewhat True or Sometimes True**	2 **Very True or Often True**	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	**PN**
2. My child gets headaches when he/she am at school.	O	O	O	**SH**
3. My child doesn't like to be with people he/she does't know well.	O	O	O	**SC**
4. My child gets scared if he/she sleeps away from home.	O	O	O	**SP**
5. My child worries about other people liking him/her.	O	O	O	**GD**
6. When my child gets frightened, he/she fells like passing out.	O	O	O	**PN**
7. My child is nervous.	O	O	O	**GD**
8. My child follows me wherever I go.	O	O	O	**SP**
9. People tell me that my child looks nervous.	O	O	O	**PN**
10. My child feels nervous with people he/she doesn't know well.	O	O	O	**SC**
11. My child gets stomachaches at school.	O	O	O	**SH**
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	**PN**
13. My child worries about sleeping alone.	O	O	O	**SP**
14. My child worries about being as good as other kids.	O	O	O	**GD**
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	**PN**
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	**SP**
17. My child worries about going to school.	O	O	O	**SH**
18. When my child gets frightened, his/her heart beats fast.	O	O	O	**PN**
19. He/she child gets shaky.	O	O	O	**PN**
20. My child has nightmares about something bad happening to him/her.	O	O	O	**SP**

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 2 of 2 (to be filled out by the RCTGPV)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. O { "ej kn f "y qttkgu about things working out for j ko 1j gt.	O	O	O	**GD**
22. When o { "ej kn f getu frightened, j g1uj g sweatu a lot.	O	O	O	**PN**
23. O { "ej kn f "ku a worrier.	O	O	O	**GD**
24. O { "ej kn f "getu really frightened for no reason at all.	O	O	O	**PN**
25. O { "ej kn f "ku afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for m{ "ej kn f to talk with people j g1uj g dogun't know well.	O	O	O	**SC**
27. When o { "ej kn f getu frightened, j g1uj g feelu like j g1uj g "ku choking.	O	O	O	**PN**
28. People tell me that o { "ej kn f worrkgu too much.	O	O	O	**GD**
29. O { "ej kn f "f qgup)v like to be away from j ku1j gt family.	O	O	O	**SP**
30. O { "ej kn f "ku afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. O { "ej kn f worrkgu that something bad might happen to j ku1j gt parents.	O	O	O	**SP**
32. O { "ej kn f feelu shy with people j g1uj g dogun't know well.	O	O	O	**SC**
33. O { "ej kn f "worrkgu about what is going to happen in the future.	O	O	O	**GD**
34. When o { "ej kn f getu frightened, j g1uj g feelu like throwing up.	O	O	O	**PN**
35. O { "ej kn f worrkgu about how well j g1uj g dogu things.	O	O	O	**GD**
36. O { "ej kn f ku scared to go to school.	O	O	O	**SH**
37. O { "ej kn f "y qttkgu about things that have already happened.	O	O	O	**GD**
38. When o { "ej kn f getu frightened, j g1uj g feelu dizzy.	O	O	O	**PN**
39. O { "ej kn f feelu nervous when j g1uj g "ku with other children or adults cpf "j g1uj g "j cu "vq "f q "something while they watch j ko 1j gt (for example: tgcf "cnqwf ."ur gcm "r nc{ "c "game, play a sport).	O	O	O	**SC**
40. O { "ej kn f feelu nervous when j g1uj g "ku "going to parties, dances, or any r nceg "y j gtg "vj gtg "y km "dg "people that j g1uj g dogun't know well.	O	O	O	**SC**
41. O { "ej kn f "ku shy.	O	O	O	**SC**

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

The SCARED is available at no cost at www.wpic.pitt.edu/research under tools and assessments, or at www.pediatric bipolar.pitt.edu under instruments.

To be filled out by one or both parents/guardians. You may print multiple copies if multiple households. (2 pages)

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ______________________________ Date of Birth: _______________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ
National Institute for Children's Health Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ____________ Child's Name: ______________________________ Date of Birth: ______________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ____________

Total number of questions scored 2 or 3 in questions 10–18: ____________

Total Symptom Score for questions 1–18: ____________

Total number of questions scored 2 or 3 in questions 19–26: ____________

Total number of questions scored 2 or 3 in questions 27–40: ____________

Total number of questions scored 2 or 3 in questions 41–47: ____________

Total number of questions scored 4 or 5 in questions 48–55: ____________

Average Performance Score: ____________

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ
National Institute for Children's Health Quality

McNeil
Consumer & Specialty Pharmaceuticals

To be filled out by patient's teacher. You may print multiple copies if multiple teachers. (2 pages)

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: ______________

Today's Date: __________ Child's Name: ______________________ Grade Level: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: __________.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

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NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0351

Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: __________

Today's Date: ________ Child's Name: ______________________ Grade Level: ______________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: ____

Mailing address: ____

____

Fax number: ____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ______________

Total number of questions scored 2 or 3 in questions 10–18: ______________

Total Symptom Score for questions 1–18: ______________

Total number of questions scored 2 or 3 in questions 19–28: ______________

Total number of questions scored 2 or 3 in questions 29–35: ______________

Total number of questions scored 4 or 5 in questions 36–43: ______________

Average Performance Score: ______________

Please fax responses to:

Reading Pediatrics

Fax: 610-621-0127

Attn: Behavioral Health Team

American Academy of Pediatrics

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NICHQ
National Institute for Children's Health Quality

11-20/rev0303

To be filled out by patient. (AGES 11 AND UP)
Please allow your child to answer these questions in private.

PHQ-9 modified for Adolescents (PHQ-A)

Name: ___________________________ **Clinician:** ________________________ **Date:** ________

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Limited List of Local Behavioral Health Providers

****Family Guidance Center**
https://familyguidancecenter.com/site
1235 Penn Ave., Wyomissing, PA 19610
Additional offices in Kutztown, Hamburg, and Boyertown
610-374-4963, *3482

**Springfield Psychological
https://springpsych.com/
560 Van Reed Rd, Ste 301
Wyomissing, PA 19610
610-544-2110, ext. 163

Alternative Consulting Enterprises #
https://altcsll.org
527 East Lancaster Ave., Shillington, PA 19607
610-796-8110

Concern Counseling #
https://concern4kids.org
22-24 North Franklin St., Fleetwood, PA 19522
610-944-0445
1120-C Hobart Ave., Wyomissing, PA 19610
610-371-8035

PA Counseling
https://pacounseling.com/reading-wyomissing/
1733 Penn Ave., West Lawn, PA 19609
610-670-7270

Berkshire Psychiatry and Behavioral Health Services #
https://berkshirepsychiatric.com/
716 North Park Rd., Wyomissing, PA 19610
610 375-0544
640 Walnut St. Suite 303, Reading PA 19601
610-208-8860

Empowerment Behavioral Health
https://empowermentbh.com
833 North Park Rd, Suite 101, Wyomissing, PA 19610
610-396-5094

Child and Family Support Services
https://cfss-pa.com
1418 Clarion St., Reading, PA 19601
610-376-8558

Berks Counseling Center #
https://berkscounselingcenter.org
645 Penn St., 2nd floor, Reading, PA 19602
610-373-4281

Berks Counseling Associates
https://www.berkscounselingassociates.com
1150 Berkshire Blvd., Ste 250, Wyomissing, PA 19610
610-373-7005

Commonwealth Clinical Group
https://commwealthclinicalgroup.com
450 South 5th St., Reading, PA 19602
844-331-3551; 610-372-5645

DGR Behavioral Health
https://dgrbehavioralhealth.com
2201 Ridgewood Rd., Ste. 400, Wyomissing, PA 19610
610-378-9601

Advanced Counseling and Testing Solutions
https://www.advancedcounselingandtestingsolutions.com/
4 Wellington Blvd, Ste. 101, Wyomissing, PA
484-987-7116

Reading Counseling Services
https://readingcounselingservices.com/
122 W. Lancaster Ave., Shillington, PA 19607
(888) 768-4372

Mind Matters
https://www.mymindmatterscounseling.com/
Van Reed Office Plaza
2209 Quarry Drive, A-10
Reading, Pennsylvania 19609
(844) 696-4631

Limited List of Local Behavioral Health Providers

Creative Health Services
https://creativehs.org/
321 N. Furnace St., Ste. 40, Birdsboro, PA 19508
610-404-8825
5th and Montgomery Ave. Boyertown, PA 19512
610-369-7271
11 Robinson St., Pottstown, PA 19464
484-941-0500

Fairview Counseling
https://fairviewcounseling.org
1255 Perkiomen Ave., Reading, PA 19602
610-396-9091

Holcomb Behavioral Health Systems
https://chimes.org/about/chimes-family/holcomb-behavioral-health-systems
1011 Reed Ave, Ste. 900, Wyomissing, PA 19610
610-939-9999

Paragon Behavioral Health Services
https://paragonbhs.com
510 N. Park Rd., Ste. 2, Wyomissing, PA 19610
484-516-2330

Malvern Community Health Services
https://malvernchs.com/clients/reading
144 N. 6th St., Reading, PA 19601
610-375-74754
1610 Medical Dr., Ste. 310
Pottstown, PA 19464
610-970-5000

Shoudt and Reilly Psychological Services
https://shoudtreillypsychologicalservices.com
6720 E. Perkiomen Ave., Birdsboro, PA 19508
610-544-2110

River of Hope Therapeutic Ministries
(Christian Counselors):
https://riverofhope.org
100 Forney Rd., Lebanon, PA 17042
717-274-3950

Furnace Creek Counseling
https://www.furnacecreekcounseling.com/
140 Penn Ave., Ste. 2, Robesonia, PA 19551
610-750-9135

Center for Mental Health (Tower Health)
https://towerhealth.org
Sixth and Spruce Sts.
Building K
Reading, PA 19611
484-628-8070

Everlasting Wellness
https://everlastingwellnesscounseling.com/
2913 Windmill Rd.
Wyomissing, PA 19608
610-379-2041

Emotional Wellness
http://emwell.org/services/
The Spine and Wellness Center
3933 Perkiomen Avenue, Suite 102
Reading, PA 19606
610-779-7272

Jeff Laubach
2209 Quarry Dr. Suite C-36
West Lawn, PA 19609
610-685-8621

Empowering Minds
3803 Kutztown Road
Laureldale, PA 19605
(610) 859-4242

****Betterview Counseling and Trauma Recovery**
https://betterviewcounseling.com
833 N. Park Road, Suite 207
Wyomissing, PA 19610
484-709-1381

Reading Pediatrics

40 Berkshire Court Wyomissing, PA 19610
(P) 610-374-7400 (F) 610-374-4252

Authorization for Release of Information

Client Name: ______________________________ Date of Birth: ________________

I hereby authorize Reading Pediatrics to exchange information with :

Agency/Name : ______________________________ Phone : ________________

Address : ______________________________ Fax: ________________

____

The information to be RELEASED for the purpose of coordination of care is :

( ) Psychiatric Evaluation	( ) Discharge Summary	( ) Medications	( ) Treatment Plans
( ) Medical History	( ) Lab Reports	( ) Individual Education Plan	( ) Integrated Summary
	( ) Psychological Evaluation	( ) Immunization Records	( ) Substance Abuse Information

The information to be OBTAINED is :

( ) Psychiatric Evaluation	( ) Discharge Summary	( ) Medications	( ) Treatment Plans
( ) Medical History	( ) Lab Reports	( ) Individual Education Plan	( ) Integrated Summary
	( ) Psychological Evaluation	( ) Immunization Records	( ) Substance Abuse Information

I have been told that, in order to protect the confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for 1 year after the date of my signature, unless specified below. I also understand that I may revoke this authorization except to the extent that action has already been taken. Refusal to disclose all or some health care information may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits/insurance or other adverse consequences. Your signature or refusal to sign this consent will not solely be used as a basis for treatment.

This consent shall be in effect from ________________ until ________________
(not to exceed 1 year)

DO YOU WANT A COPY OF THE RELEASE? ___YES ___NO

Signature of Client (14 years and above) ______________________ Authority/Relationship to Client ________ Date of Signature

Representative (Parent, Legal Guardian) If Client is under the age of consent. ______________________ Authority/ Relationship to client ________ Date of Signature

Witness : ______________________ Date : ________________

ATTENTION

PARENTS OF CHILDREN WITH SPECIAL HEALTHCARE NEEDS

Chronic Conditions: Physical, Developmental, Behavioral, or Emotional

Are you aware your child may be eligible for medical assistance?

Medical Assistance Benefits are **not** dependent on parent's income
Your child may be eligible even if you have other insurance
Medical Assistance can pay for services **not** covered by other insurance

For More Information:
CALL: 1-800-986-KIDS
OR
www.compass.state.pa.us

NOTE -Mark application "MA only child with disabiity"

Why You Should Have Medical Assistance (MA) for Your Child
And the Steps to follow to obtain MA

Regardless of whether the child is covered under private insurance, a child with special healthcare needs should have medical assistance. Why? Because medical assistance covers many things that are not covered by private insurance.

Medical assistance (hereinafter "MA") has the broadest coverage of medical and mental health services for individuals under 18 of any insurance plan. Services provided under MA that private insurance often does not cover include behavioral health services, in-home nursing services, in-home personal care services, diapers, nutritional supplements, prescriptions and transportation to medical appointments. Behavioral health services are often referred to as "wraparound" services and included a Therapeutic Support Staff (TSS), a Mobile Therapist (MT) and a Behavior Specialist Consultant (BSC) who all work together to provide behavior support to children at home and at school. MA also covers various types of therapy such as occupational, physical, and speech and language. Often private insurance companies place a cap on these services whereas MA does not. MA can be a child's only insurance or it can be secondary. Where it is secondary, MA will cover services not covered by insurance, including co-pays, and can cover the therapies in addition to those covered by insurance.

A common misconception about MA is that income of the parents is considered; however, income of the parents is irrelevant to eligibility. Why? Because of Category PH 95, which is considered a "loophole" and allows qualified individuals to obtain MA without consideration of the parents' income. Generally speaking, in order to qualify under the loophole, the child must have a disability or condition that limits his or her ability to perform basic functions including physical, neurological, sensory, cognitive, and psychological functioning.

Thus, the majority of children who have an Individualized Education Plan (IEP) will be eligible for MA. In order to establish that your child meets these standards you will need to provide any medical reports, therapy reports, guidance counseling reports and Evaluation Reports (ERs) prepared by your school district, intermediate unit or early intervention program.

To apply, you can call 1-800-986-5437 and request to begin the application over the phone. You can also apply online at https://www.compass.state.pa.us

In addition, documentation of your child's disability (diagnosis), you will need to provide the child's social security card, birth certificate, proof of address and documentation of income in the child's name (interest or dividends and earnings of a child's income are considered)

You will also need to obtain a Supplemental Security Income (SSI) determination. SSI provides a monthly check and MA to qualified persons who meet Social Security's disability criteria and have low income and assets. Even if you are not seeking SSI, your local county office may advise that you need an SSI eligibility determination to obtain MA. To receive an SSI eligibility determination, you simply call 1-800-772-1213 and follow the prompts to speak to a representative to set up a phone or in-person interview. Keep in mind that parental income matters for SSI so many families will be denied.

Thus, be prepared to have documentation of income available for the interview. If you do not meet SSI requirements for income reasons, you will receive a denial letter which you then need to provide to your county case worker.

You will receive a DAP (Disability Advocacy Program) referral packet and the county caseworker typically will highlight the areas within the packet that require your signature or initials. Once you receive the packet, sign the required forms and mail back immediately. Your signature will allow the county case worker to follow the progress of the SSI application.

Having medical coverage for your child is essential, especially when you have a child with special needs. Medical assistance provides extensive coverage that private insurance may not.

Income of the parent is not relevant to qualification for MA. Thus, parents who have a child with a disability should take the necessary steps to ensure they have MA for their child.

MA Application Tips for Applying due to Patient's Behavioral Health needs:

1. Plan to spend 1.5-2 hours completing the application.
2. Use the big blue box on the left side of the page. Box states "Apply Now"
3. Take a picture of or write down your efile # once provided in the event that you are booted out of the program while completing the application process.
4. Gather pertinent information before starting for all household members.
    a. Name
    b. date of birth
    c. driver's license numbers
    d. social security numbers
5. For adult members, questions are asked regarding:
    a. name and location of employers
    b. income prior to taxes
    c. amount earned per hour/salary
    d. how often is pay received
    e. when was the last payment
    f. how many miles do you drive to work
    g. do you own a car, do you pay $ for transportation to someone else
6. Does anyone have a serious medical condition? Yes.
    a. This will eventually generate a drop-down box where you add patient's diagnoses (all medical and behavioral health) and a statement that patient has been recommended for intensive in-home services.
    b. Needs to be brief as box is not long
7. Does anyone have any paid or unpaid medical bills in the past 90 days? Answer yes if patient has been to any provider in the past 3 months.
8. At the end of the application, there is a box for comments. Please note "I/we believe that patient qualifies for MA under PH95.
9. You may be told that you must file for SSI or SSD benefits. You will have to complete the process if you want approval for MA, but may not qualify based on family income.