

PEDIATRIC HEALTHCARE ASSOCIATES
(203) 452-8322

Dear Caregiver / Patient,

Today you are being asked to complete one or more of the following developmental and/or emotional tests. The appropriate tests, based on your child's age, are included in this packet.

- ☐ **ASQ Screening** – for all children 9 months to 15 months of age (this will be given in the office)
- ☐ **MCHAT Test** – done at 18 months and 24 months
- ☐ **Pediatric Symptom Checklist (PSC-17)** – for all children 6 to 15 years of age
- ☐ **Modified Testing for Teens (PHQ-9)** – for all teens 16 & 17 years of age
- ☐ **Patient Health Questionnaire (PHQ-9)** – 18 years and older
- ☐ **Edinburgh Postnatal Depression Scale (EPDS)**
- ☐ **Social Determinants of Health (SDoH)** – all annual well exams
- ☐ **Preschool Pediatric Symptom Checklist (PPSC)** – 30 months to 5 years of age
- ☐ **Tuberculosis Screening**

All of these standardized tests are recommended by the American Academy of Pediatrics to determine any signs of developmental and/or emotional concerns.

These tests will be submitted to your insurance company. Depending on your plan, the testing might be subject to a deductible or co-insurance.

<u>If so, you will be billed for any patient balance.</u>

Tuberculosis Risk-Assessment Questionnaire

1. Was this child born in a country other than the United States? YES NO

   If yes, where was he/she born and when did they come to the U.S.?

   _____

2. Was this child's mother or father born in a country other than the United States? YES NO

   If yes, where were they born and when did they come to the U.S.?

   _____

3. Has this child traveled to another country since their last physical exam? YES NO

   If yes, where did he/she travel? _____

   With whom did he/she stay? Friends / Relatives Hotel

   Were they there for one month or more? YES NO

4. Has this child been exposed to anyone with tuberculosis or a positive TB skin test since his/her last physical exam? YES NO

PHQ-9: MODIFIED FOR TEENS

PATIENT: _____ **DOB:** _____ **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 by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999). Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000).

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99 Hawley Lane
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15 Corporate Dr.
Trumbull, CT 06611

Shelton
Business Office
100 Beard Sawmill Rd. - 430
Shelton, CT 06484

SDoH Screening Tool

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		Yes / No
	In the last 12 months*, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work or study?** *(leave blank if you do not have children)*	Y N
$	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Do you often feel that **you lack companionship?**	Y N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

**time frames can be altered as needed*

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Pre-Concussion Screening
also-known-as
Baseline ImPACT Testing



We at PHA recommend that all student athletes age 12 and older take the ImPACT test every two years. The test is used to establish a baseline for future use, helping guide the best treatment if your child sustains a concussion.

This 25 minute computerized test evaluates multiple aspects of brain function.

Baseline ImPACT Test costs $30.00 which is due at the time of service.

Call our office (203) 452-8322 to schedule an appointment for your child.

PHA

Pediatric Healthcare Associates

www.PHA4KIDS.com

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Pre-Concussion Screening
also known as
Baseline ImPACT Testing

What is a Pre-Concussion Screening (Baseline ImPACT Test) & why is it important?

- The test is to establish a baseline for future use in helping to determine the best post concussion treatment if your child should be injured in a sporting or non-sporting event.
- ImPACT does not diagnose a concussion but informs the provider if there is a change in the way your child's brain functions after an injury.
- Baseline scores are valid for two years and should be repeated if two years has lapsed.

What is ImPACT testing?

- ImPACT testing is a computerized brain measurement tool for children and teens who have sustained a concussion.
- Through a series of computerized tests completed in our office, ImPACT identifies subtle changes in brain function, evaluates post-injury condition, and tracks recovery.
- By comparing pre-injury baseline and post-injury tests results, ImPACT can help track recovery following a concussion.

How does ImPACT testing work?

- An ImPACT test is a 25-minute computerized assessment test that evaulates multiple aspects of brain function including verbal memory, visual memory, processing speed, reaction time and post-concussive symptoms.
- By comparing pre-injury baseline and post-injury test results, it helps determine when brain function has returned to normal and if it is safe to return to sports and school activities.

Who can take the ImPACT test?

- We recommend that all student athletes age 12 and older (for example: football players, soccer players, hockey players, baseball players, rugby players, cheerleaders, softball players, skateboarders, gymnasts, lacrosse players, cyclists, and skiers) take the test.

How can my child get tested?

- Call PHA (203) 452-8322 for an appointment.
- The Baseline ImPACT Tests costs $30.00. The test is not covered by insurance and payment is due at time of service.