Partners in Pediatrics

An affiliate of Children's Hospitals and Clinics of Minnesota

BROOKLYN PARK OFFICE
8500 Edinbrook Parkway
Brooklyn Park MN 55443
(763) 425-1211
FAX (612) 874-2907

CALHOUN OFFICE
3910 Excelsior Boulevard
St Louis Park, MN 55416
(952) 562-8787
FAX (612) 874-2909

MAPLE GROVE OFFICE
Bass Lake Center
12720 Bass Lake Road
Maple Grove MN 55369
(763) 559-2861
FAX (612) 874-2902

PLYMOUTH OFFICE
WestHealth
2855 Campus Drive, #350
Plymouth MN 55441
(763) 520-1200
FAX (612) 874-2908

ROGERS OFFICE
13980 Northdale Boulevard
Rogers MN 55374
(763) 428-1920
FAX (612) 874-2916

SCHOOL PROGRESS EVALUATION

Thank you for choosing Partners in Pediatrics for your child's medical evaluation for attention and school difficulties. We are committed to performing this evaluation in the comprehensive manner that each child deserves. The evaluation and treatment options available often involve long-term strategies, and it is more important to do this carefully than to do it quickly. We realize that waiting may be difficult, but please be patient as we arrange the evaluation process for your child.

The evaluation consists of two 40 minute visits over approximately two weeks, with a follow up visit 3 - 4 weeks later if treatment is started. The first visit is to review the historical and behavioral information with the parents only. The second visit is to interview and perform the physical and neurological examinations of the child with the parents present.

If medication treatment is deemed necessary after this initial evaluation, we then require close follow up including a recheck within 3 - 4 weeks of starting medication. Frequent appointments may be necessary initially as the appropriate medication and dosage are established. Once stabilized on medication, patients are required to be seen at least every 4 months for follow up.

Please find enclosed separate parent and teacher questionnaires. These forms are used to gather historical and diagnostic information necessary for the evaluation. Please fill out the entire parent packet and give the teacher packet to one or more of your child's teachers. Choose those teachers who know your child best. If your child is in Middle School or High School each teacher will need to complete a packet. Ask the teachers to complete the forms as soon as possible. Please also obtain copies of any previous school or private psychological evaluations and a recent report card.

After we receive your completed forms we will contact you to schedule the appointments. All of the forms that are needed for this evaluation can also be found on our website. www.pipstop.com. Please return them in the enclosed envelope as soon as they are completed.

Services for this evaluation **MAY OR MAY NOT BE** covered under your health plan. Some plans may provide a different level of benefit for evaluations such as these, placing them under mental health rather than medical benefits. Please contact your insurance company directly about this coverage prior to your evaluation. You may contact our business office to discuss payment arrangements.

Please contact your office if you have any problems.

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Children's MINNESOTA
Partners in Pediatrics

SCHOOL PROBLEMS EVALUATION
MEDICAL HISTORY FORM

Child's name: _____

Birthdate: _____ Date form filled out: _____

Your name: _____ Primary Phone: _____

Relationship to child: _____ Secondary Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Name of School: _____ Grade: _____

Referred by: _____

Child's private physician: _____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

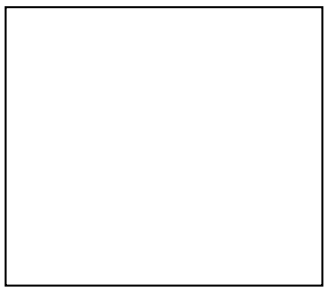
Date Name of Physician, psychologist, agency, or clinic

_____

_____

_____

Please attach a recent picture:



Name: _____ Date of Birth: _____

Please list the problems with which you want help for your child:

1. _____
2. _____
3. _____
4. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

_____

_____

SCHOOL

Please describe your child's current classroom placement and services (attach an Individual Educational Plan [IEP] and copies of any school psycho-educational reports if available):

Special Services Time/days per week

_____

_____

_____

Please indicate current classroom interventions:

- ❒ Behavior chart
- ❒ Seating preference
- ❒ Time to think or behavior room
- ❒ Social skills group
- ❒ Other _____

School performance: What has the school told you about your child's:

Behavior? _____

_____

Work completion? _____

_____

Academic progress? _____

_____

Does your child often bring home work that should have been done during class time? ❒ Yes ❒ No

Handwriting/ neatness: _____

_____

Please describe previous day care, preschool or school problems:

Grade/year School/Center name Problems

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____

HOME/FAMILY

Family Member	Name/Relationship	Years of School/Degree	Occupation
Parent 1			
Parent 2			
Step Parent 1			
Step Parent 2			

Parents are: ❒ married ❒ separated ❒ divorced ❒ never married

Please share any history of significant (if any) marital problems: _____

Custody arrangements if applicable: _____

Who lives at home with this child? _____

Briefly describe any behavior or family issues that bother you in regard to this child:

Please describe any conflict surrounding homework: _____

Please describe how you discipline your child: _____

SOCIAL

How many close friends does your child have? _____

Describe any problems your child may have in making and keeping friends: _____

Please describe any aspect of your child's social life that bothers you: _____

List the organized or leisure time activities your child participates in (e.g.., sports, scouts, religious, free time play):

How many hours per day does your child watch TV and play video games? _____

Name: _____ Date of Birth: _____

SELF-ESTEEM

How do you feel these problems are affecting your child's self-esteem? _____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Was this child adopted? ❒ Yes ❒ No

PREGNANCY

Was this pregnancy planned? ❒ Yes ❒ No

PREGNANCY COMPLICATIONS	Yes	No
Bleeding		
Premature labor		
High blood pressure		
Toxemia		
Infections		
Weight gain less than 15 lbs.		
Diabetes		
Smoking		
Drug use *		
Alcohol use: # of drinks/day _____		
Emotional or family problems *		
Previous stillborns/miscarriages		

Specify any medications/drugs or other details:

_____

_____

_____

_____

_____

_____

_____

LABOR AND DELIVERY:

Length of pregnancy: _____ Type of delivery: ❒ Vaginal ❒ Cesarean

Mother's age at delivery: _____

Complications:

❒ fetal distress (heart rate drop)
❒ meconium (bowel movement) passage before birth
❒ forceps use
❒ breech delivery
❒ other, describe _____

NEWBORN HISTORY:

Birth weight: _____ lbs. _____ oz.

Complications at birth (check those that apply):

❒ None
❒ Needed oxygen
❒ Difficulty breathing/respiratory distress
❒ Treated in an intensive care unit (NICU)
❒ Jaundice
❒ Low blood sugar
❒ Infection/ pneumonia
❒ Other: _____

Name: _____ Date of Birth: _____

GROWTH

Has your child had any problems with (if yes, please describe):

Weight loss or gain: ❒ No ❒ Yes: _____

Growth in height or length: ❒ No ❒ Yes: _____

Head size: ❒ No ❒ Yes: _____

Additional details or comments: _____

_____

_____

DEVELOPMENT

Did your child's development seem normal compared to other children? ❒ No ❒ Yes

Developmental milestone	Age Achieved
Rolled over	
Sat alone	
Walked alone	
First words (mama-dada)	
Two word sentences	
Toilet trained – days	
Toilet trained – nights	
Dress self	

BEHAVIOR HISTORY:

If your child has experienced any of these behavior problems, please record the ages they occurred.

BEHAVIOR	NO	YES	AGES
Colic			
Infant feeding problems			
Difficulty falling asleep			
Difficulty staying asleep			
Excessive crying			
Tantrums			
Difficulty being consoled			
Overactivity or hyperactivity			
Difficulty keeping to a schedule			
Difficulty being satisfied or easily bored			
Thumb sucking			
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Name: _____ Date of Birth: _____

BIOLOGICAL FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family other than your child may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

FAMILY HISTORY	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Others (Specify)
LEARNING					
Difficulty with reading					
Difficulty with arithmetic/math					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Mental retardation					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression/bipolar					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

Father's age: _____

Mother's age: _____

Sister(s) name and ages: _____

Brother(s) name and ages: _____

Name: _____ Date of Birth: _____

FAMILY HEART HISTORY:

If a member of your child's family has had any of these medical problems, please record their relationship to your child.

PROBLEM	NO	YES	RELATIONSHIP
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

CHILD'S HEART HISTORY:

If your child has experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

CHILD'S MEDICAL HISTORY:

Are immunizations up to date? ❒ No ❒ Yes (Please include a copy of current immunization records)

Describe any serious reactions: _____

List any known allergies to medications, foods, pollens or inhalants: _____

_____

_____

Describe any hospitalizations or surgery (date, reason, problems): _____

_____

_____

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): _____

_____

_____

Name: _____ Date of Birth: _____

MEDICATIONS:

Please list currently prescribed or over the counter medications taken and their doses:

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS:

If your child has experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods Problems			
Age menstruation started _____			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other (specify)			

Partners in Pediatrics

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PARENT SCHOOL PROGRESS INITIAL EVALUATION

Parent to Complete

Child's Name: _____ Date of Birth: _____ Today's Date: _____

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.

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 and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	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 (i.e. "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
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

Continued on Reverse

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

Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
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. Relationships with parents.	1	2	3	4	5
53. Relationships with siblings.	1	2	3	4	5
54. Relationships with peers.	1	2	3	4	5
55. Participation in organized activities (e.g. teams)	1	2	3	4	5

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS**

❑ Brooklyn Park office
8500 Edinbrook Parkway
Brooklyn Park MN 55443
Phone: 763-425-1211
Fax: 612-874-2907

❑ Calhoun office
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❑ Plymouth office
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Plymouth MN 55441
Phone: 763-520-1200
Fax: 612-874-2908

❑ Rogers office
13980 Northdale Boulevard
Rogers MN 55374
Phone: 763-428-1920
Fax: 612-874-2916

Provider Initials: _____

Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information Fax: 612-813-5980

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:

_____
_____
_____
_____
_____
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_____
_____
_____

How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

Information needed from the following clinics:
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____
☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's

☐ Email_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

ROI

Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information Fax: 612-813-5980

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:

_____
_____
_____
_____
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_____
_____
_____

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*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

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Information needed from the following clinics:
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☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____
☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's

☐ Email_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
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- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

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Rogers MN 55374
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FAX (612) 874-2916

Dear Teacher:

One of your students is currently being evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of academic and behavioral rating scales.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires. These forms may include:

For Elementary Students:
Teacher School Progress Initial Evaluation Form

For Middle School or High School Students:
Middle/High School Progress Report (please copy and have each teacher fill out)

For Elementary students, generally, the teacher who spends the most time with the child should complete the teacher rating scale. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate rating scale from each teacher.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. If you have misplaced the forms, you can print them from our website www.pipstop.com.

The forms should be returned to the parents.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the enclosed materials, please do not hesitate to contact us.

Sincerely,

Partners in Pediatrics

Partners in Pediatrics

An affiliate of Children's Hospitals and Clinics of Minnesota

TEACHER SCHOOL PROGRESS INITIAL EVALUATION

Teacher to Complete

Child's Name: _____ Grade Level: _____ Today's Date: _____

Teacher's Name: _____ Class Name/subject: _____ Class Time /Period: _____

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 when given directions 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 (butts into conversations/games).	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 and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	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 (i.e. "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
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

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

Continued on Reverse

Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
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 ACADEMIC PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
48. Reading – accuracy of work completed	1	2	3	4	5
49. Mathematics – accuracy of work completed	1	2	3	4	5
50. Written expression - accuracy of work completed	1	2	3	4	5
CLASSROOM BEHAVIORAL PERFORMANCE	**EXCELLENT**	**ABOVE AVERAGE**	**AVERAGE**	**SOMEWHAT OF A PROBLEM**	**PROBLEMATIC**
51. Relationships with peers	1	2	3	4	5
52. Following directions	1	2	3	4	5
53. Disrupting class	1	2	3	4	5
54. Assignment completion	1	2	3	4	5
55. Organizational skills	1	2	3	4	5

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS** or send to parents

❑ Brooklyn Park office
8500 Edinbrook Parkway
Brooklyn Park MN 55443
Phone: 763-425-1211
Fax: 612-874-2907

❑ Calhoun office
3910 Excelsior Boulevard
St Louis Park, MN 55416
Phone: 952-562-8787
Fax: 612-874-2909

❑ Maple Grove office
12720 Bass Lake Road
Maple Grove MN 55369
Phone: 763-559-2861
Fax: 612-874-2902

❑ Plymouth office
2855 Campus Drive, #350
Plymouth MN 55441
Phone: 763-520-1200
Fax: 612-874-2908

❑ Rogers office
13980 Northdale Boulevard
Rogers MN 55374
Phone: 763-428-1920
Fax: 612-874-2916

Provider Initials:_____