Stony Brook Medicine

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REFERRAL & RECORDS POLICY

Effective immediately it will be the policy of Neurology Associates of Stony Brook, U.F.P.C. that if you require a referral for your visit you must present it at the time of your service or your appointment will be rescheduled. This includes paper referrals and/or your referrals that can be retrieved on line. Please provide your paper referral and/or your referral number printed off line to our front desk staff.

Please be advised that if you are in need of multiple pages of your medical record that there is a fee and a records release will need to be signed. Please allow 7-10 business days for this process to be completed. Multiple pages of a medical record will not be produced at the front desk of the outpatient office.

Thank you for your understanding with these matters.

Acknowledgement of policies:

Patient / Guardian Signature: ______________________________

Date: ____________________

Patient Name: ______________________________
(print)

Ambulatory Care Consent Form

Patient Name: ______________________ Date of Birth: ______________

MRN: ______________________ ENC#: ______________________

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff.

____

Signature of Patient or Patient Representative

____

Print Name of Patient or Personal Representative

____

Relationship, if signed by person other than Patient

____

Date

____

Description of Personal Representative's Authority

SBUH2012N106

Stony Brook Organized Care Arrangement (SBOHCA) Ambulatory Care Acknowledgement Form

Patient Name: ______________________ Date of Birth: ______________

MRN: ______________________ ENC#: ______________________

By signing below I acknowledge that I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information

____
Signature of Patient or Patient Representative

____
Print Name of Patient or Personal Representative

____
Relationship, if signed by person other than Patient

____
Date

____
Description of Personal Representative's Authority

SBUH2012N106

Stony Brook Medicine

Name: ______________________________
(Last) (First) (MI)

Department of Neurology
Pediatric Patient History Form

Date: ____________ MRN: ____________ Date of Birth: ____________ ☐ Male ☐ Female

Form Completed By (check one): ☐ Parent ☐ Patient ☐ Other (name): ____________
Pediatrician's Name: ____________ Pediatrician's Address: ____________
Other Physician(s): ____________

Instructions: Please print the requested information or place a check mark "✓" where appropriate. DO NOT write in shaded area.

Reason for referral: ____________

Birth History:
What was the baby's birth weight: ____________ Was baby full term: ☐ No ☐ Yes
Premature: Gestational Age: ______ weeks

Was delivery vaginal: ☐ No ☐ Yes Complicated? ☐ C-section
☐ breech ☐ failure to progress
☐ fetal distress ☐ other: ____________

What were the baby's Apgar scores (if known): ____________

Mother's age at delivery: ______ Baby's birth order: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th

Was baby in regular newborn nursery: ☐ No ☐ Yes Neonatal intensive care unit: ☐ No ☐ Yes, how long: ______

Was baby discharged from hospital with mother: ☐ No ☐ Yes

Developmental History:

Medical Team Use Only

Did child *walk* by age 14 months: ☐ No ☐ Yes
Did child *speak short phrases* by age 24 months: ☐ No ☐ Yes
At what age (months) did the child *speak first word:* ______ *short phrases:* ______
roll over: ______ *crawl:* ______ *sit:* ______ *walk:* ______ *ride tricycle:* ______
Has your child had any delayed milestones: ____________
Was the child enrolled in an Infant (Early Intervention) Program: ☐ No ☐ Yes
Why / What were the problems: ____________

Education History:

Medical Team Use Only

Present grade: ______ Did your child attend preschool: ☐ No ☐ Yes
Were any problems noted by a teacher: ☐ No ☐ Yes
Were there problems with attention: ☐ No ☐ Yes
activity: ☐ No ☐ Yes
behavior: ☐ No ☐ Yes
scissors: ☐ No ☐ Yes
Was it therapeutic (special education): ☐ No ☐ Yes
Name of School: ____________

Is your child in regular class: ☐ No ☐ Yes
Special Education: ☐ No ☐ Yes
Resource Room: (☐ reading ☐ math ☐ all) ☐ No ☐ Yes
Has your child ever failed a grade: ☐ No ☐ Yes

SBUH2013N032

Stony Brook Medicine

Name: ______________________________
(Last) (First) (MI)

Department of Neurology
Pediatric Patient History Form

Past Medical History:

Has your child ever been *hospitalized*: ☐ No ☐ Yes, describe: ______________
Has your child had any serious *injuries/broken bones*: ☐ No ☐ Yes, describe: ______________
Has your child ever received a *blood transfusion*: ☐ No ☐ Yes Year(s): ______________

Immunization History:

Are your child's immunizations up to date: ☐ No ☐ Yes

Pneumococcal (pneumonia):	☐ Unknown	☐ No	☐ Yes,	Year: ______
Hepatitis B:	☐ Unknown	☐ No	☐ Yes,	Year: ______
Influenza (flu):	☐ Unknown	☐ No	☐ Yes,	Year: ______
Tetanus / Diphtheria (past 10 yrs):	☐ Unknown	☐ No	☐ Yes,	Year: ______
Measles:	☐ Unknown	☐ No	☐ Yes,	Year: ______
Mumps:	☐ Unknown	☐ No	☐ Yes,	Year: ______
Rubella:	☐ Unknown	☐ No	☐ Yes,	Year: ______
Polio:	☐ Unknown	☐ No	☐ Yes,	Year: ______

Has your child ever had the following:

			Medical Team Use Only
Strep throat:	☐ No	☐ Yes, describe: ______________	
Asthma	☐ No	☐ Yes, describe: ______________	
Heart problems:	☐ No	☐ Yes, describe: ______________	
Lung problems:	☐ No	☐ Yes, describe: ______________	
Kidney problems:	☐ No	☐ Yes, describe: ______________	
Stomach problems:	☐ No	☐ Yes, describe: ______________	
Colon problems:	☐ No	☐ Yes, describe: ______________	
Depression:	☐ No	☐ Yes, describe: ______________	
Psychiatric illness:	☐ No	☐ Yes, describe: ______________	
Alcohol/drug abuse:	☐ No	☐ Yes, describe: ______________	
Poisoning (with what):	☐ No	☐ Yes, describe: ______________	
Endocrine disorder:	☐ No	☐ Yes, describe: ______________	
Infectious disease:	☐ No	☐ Yes, describe: ______________	
Lyme disease:	☐ No	☐ Yes, describe: ______________	
Other:	☐ No	☐ Yes, describe: ______________	
Attention deficit disorder:	☐ No	☐ Yes, describe: ______________	
Stroke/ TIA:	☐ No	☐ Yes, describe: ______________	
Seizure:	☐ No	☐ Yes, describe: ______________	
Migraine:	☐ No	☐ Yes, describe: ______________	
Learning disability:	☐ No	☐ Yes, describe: ______________	

Does your child have allergies (including medications): ☐ No ☐ Yes

Medical Team Use Only

Describe: ______________________________
Medication Names: ______________________________

What medication is your child taking now:

Medication	Dose	Frequency
________	________	________
________	________	________
________	________	________
________	________	________

Any medications recently stopped:

________	________	________

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Stony Brook Medicine

Name: ______________________
(Last) (First) (MI)

Department of Neurology
Pediatric Patient History Form

Social History:

Where was your child born: ______________ Raised: ______________

Does the child live with mother and father: ☐ No ☐ Yes, if not, describe: ______________

Mother's age: __________ Education: __________ Occupation: __________

Father's age: __________ Education: __________ Occupation: __________

Has the child ever used any of the following substances:

Substance	Current Use	Previous Use	Type/Amount/Frequency	# of Years	Year Stopped
Tobacco					
Alcohol (beer/wine/liquor)					
Illicit Substances (recreational/street drugs)					
Caffeine (cofee/tea/soda)					
Other (toxins/exposure)					

Family History:

Is your child adopted: ☐ No ☐ Yes, if medical history of blood relatives, describe below:

____

Father: ☐ Alive Age: _____ ☐ Deceased Cause of Death: ______________

Mother: ☐ Alive Age: _____ ☐ Deceased Cause of Death: ______________

Please list any illnesses in the following family members:

Father: ______________

Mother: ______________

Grandparents: ______________

Brothers: ______________

Sisters: ______________

Other: ______________

Does anyone in the family have neurologic problems: ☐ No ☐ Yes, describe: __________

Does anyone in the family have psychiatric problems: ☐ No ☐ Yes, describe: __________

Does anyone in the family have problems similar to your child's problem: ☐ No ☐ Yes, describe: __________

<u>Medical Team Use Only</u>

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Stony Brook Medicine

Name: ______________________
(Last) (First) (MI)

Department of Neurology
Pediatric Patient History Form

Review of Symptoms:
Has the child had a problem related to any of the following areas:

	No	Yes	Describe	Medical Team Use Only
Constitutional (fever, weight loss)	☐	☐		
Unconsciousness	☐	☐		
Eyes	☐	☐		
Ears/Nose/Mouth/Throat	☐	☐		
Cardiovascular	☐	☐		
Respiratory (trouble breathing)	☐	☐		
GI (Nausea, vomiting, reflux, Constipation)	☐	☐		
GU (trouble with urination)	☐	☐		
For Girls: onset of menstruation	Age: ____		Last Period: ________	
Musculoskeletal (muscle or joint pain)	☐	☐		
Skin (rash, lumps, bumps)	☐	☐		
Psychiatric/Behavioral	☐	☐		
Endocrine (diabetes, thyroid, growth problems)	☐	☐		
Hematological/Lymphatic (bruising, enlarged lymph nodes)	☐	☐		
Immunological disorders	☐	☐		
Neurologic				
Staring episodes/daydreaming	☐	☐		
Hyperactivity	☐	☐		
Attention problems	☐	☐		
Double vision	☐	☐		
Tics	☐	☐		
Repetitive Habits	☐	☐		
Loss of vision	☐	☐		
Dizziness/spinning	☐	☐		
Ringing in ears	☐	☐		
Hearing loss	☐	☐		
Slurred speech/ stuttering after age 4	☐	☐		
Weakness	☐	☐		
Numbness/tingling	☐	☐		
Incoordination/clumsiness	☐	☐		
Gross motor (walking/climbing)	☐	☐		
Fine motor (hand use)	☐	☐		
Memory loss	☐	☐		
Headache	☐	☐		
Sleep disturbances	☐	☐		

Medical Team Use Only

____

____

____

Reviewed and Annotated by:

Signature: ______________________ **Date:** ____________

SBUH2013N032

Stony Brook Medicine

Ambulatory Progress Note

Pain Management

Date: ______

1) Do you have any pain? ☐ No (please skip to question 4) ☐ Yes
2) Please describe the quality/location/duration: ______
3) Measure used to alleviate pain: ______

Intensity Scale: 1 2 3 4 5 6 7 8 9 10

Follow-up: ☐ Given Pain Brochure ☐ Referral To: ______ ☐ Other: (see progress note)

Comments: ______

Patient Family Education

☐ None this encounter

This form may not reflect all teaching provided. See also Progress notes of individual disciplines.

INITIAL LEARNING NEEDS ASSESSMENT.

4) Do you prefer to learn by: ☐ Seeing (pictures/video tape, written) ☐ Hearing (audiotape, verbal cues) ☐ Doing (hands on)
5) Preferred Language: ☐ English ☐ Other ☐ Needs Interpreter
6) Are there any cultural/spiritual/religious practices you would like us to know about: ☐ No ☐ Yes
   Please List: ______
7) Do you have barriers to learning?
   Physical: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Hearing: ☐ Yes ☐ No
   Emotional: ☐ Yes ☐ No Financial: ☐ Yes ☐ No Cognitive: ☐ Yes ☐ No

Teaching Topic	Person Taught	Eval. Code#
☐ Nutrition / Diet		
☐ Use of Medications		
☐ Food / Drug Interactions		
☐ Use of Equipment		
☐ Rehab Techniques		
☐ Access Community Resources		
☐ Advance Directives		
☐ Other		

Evaluation and readiness codes:
1 = Understands and/or perform return demonstration.
2 = Needs further instruction.
3 = Unable to retain information or return demonstration.
4 = Not ready to learn / no interest.
5 = Understands information compliance questionable.
6 = Offered and Refused.

Forms / Education given:

Signature / Title: ______ ID#: ______ Date: ______ Time: ______

SBUH2012N106

Stony Brook Medicine

Learning Needs Assessment

Do any of the following apply for you?

- ☐ Impaired Vision
- ☐ Impaired Hearing
- ☐ Impaired or Speaking Problems
- ☐ Pain
- ☐ Concerns about your illness
- ☐ None of the above

What is your primary language? ________________

Do you have difficulty understanding English? ☐ Yes ☐ No

Can you read English? ☐ Yes ☐ No

Is there anything about your beliefs or culture that would be important for us to know to provide you health care? ☐ Yes ☐ No, If Yes, what? ________________

____

____

____

Learning Preference:

How do you prefer to learn?

☐ Reading ☐ Person explaining to me ☐ Seeing pictures

Is there anyone you would like to have with you during your teaching? ☐ Yes ☐ No,

If yes, whom? ________________

Patient / Designee Signature: ________________ Date: ________

Practitioner Signature: ________________ ID#: ________ Date: ________

SBUH2012N106

Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale

Child's Name: ______________________ Study ID#: ______________

Person Completing Form: ______________ Date: ______________

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well. You should circle the correct response or print your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know."

Question				
1. WHILE SLEEPING, DOES YOUR CHILD:				
Snore more than half the time?	Y	N	DK	A2
Always snore?	Y	N	DK	A3
Snore loudly?	Y	N	DK	A4
Have "heavy" or loud breathing?	Y	N	DK	A5
Have trouble breathing or struggle to breathe?	Y	N	DK	A6
2. HAVE YOU EVER SEEN YOUR CHILD STOP BREATHING DURING THE NIGHT?	Y	N	DK	A7
3. DOES YOUR CHILD:				
Tend to breathe through the mouth during the day?	Y	N	DK	A24
Have a dry mouth on waking up in the morning?	Y	N	DK	A25
Occasionally wet the bed?	Y	N	DK	A32
4. DOES YOUR CHILD:				
Wake up feeling unrefreshed in the morning?	Y	N	DK	B1
Have a problem with sleepiness during the day?	Y	N	DK	B2
5. HAS A TEACHER OR OTHER SUPERVISOR COMMENTED THAT YOUR CHILD APPEARS SLEEPY DURING THE DAY?	Y	N	DK	B4
6. IS IT HARD TO WAKE YOUR CHILD UP IN THE MORNING?	Y	N	DK	B6
7. DOES YOUR CHILD WAKE UP WITH HEADACHES IN THE MORNING?	Y	N	DK	B7
8. DID YOUR CHILD STOP GROWING AT A NORMAL RATE AT ANY TIME SINCE BIRTH?	Y	N	DK	B9
9. IS YOUR CHILD OVERWEIGHT?	Y	N	DK	B22
10. THIS CHILD OFTEN:				
Does not seem to listen when spoken to directly.	Y	N	DK	C3
Has difficulty organizing tasks and activities.	Y	N	DK	C5
Is easily distracted by extraneous stimuli.	Y	N	DK	C8
Fidgets with hands or feet or squirms in seat.	Y	N	DK	C10
Is "on the go" or often acts as if "driven by a motor."	Y	N	DK	C14
Interrupts or intrudes on others (e.g., butts into conversations or games).	Y	N	DK	C18

Thank you!