REFERRAL & RECORDS POLICY

Effective immediately it will be the policy of Neurology Associates of Stony Brook, U.E.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)
Pediatric History Form
Department of Neurology

Stony Brook Medicine

[Form fields filled out with answers]

Name: [Name]
Date: [Date]
MID: [MID]
Any medications recently stopped:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Frequency</th>
<th>Does your child have allergies (including medications):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

What medication is your child taking now:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does your child have the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your child ever received a blood transfusion:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has your child ever been hospitalized:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pediatric Patient History Form

Department of Neurology

Stony Brook Medicine
### Department of Neurology

**Pediatric Patient History Form**

- **Review of Symptoms:**
  - Has the child had a problem related to any of the following areas?
  - Constitutional: Yes/No
  - Eyes: Yes/No
  - Ears/Nose/Mouth/Throat: Yes/No
  - Cardiovascular: Yes/No
  - Respiratory: Yes/No
  - GU: Yes/No
  - GI: Yes/No
  - GU: Yes/No
  - Skin: Yes/No
  - Musculoskeletal: Yes/No
  - Neurologic: Yes/No
  - Sleep: Yes/No
  - Allergies: Yes/No

- **Last Period:**
  - Age:
  - Menstruation:

- **Neurologic:**
  - Headache:
  - Seizures:
  - Numbness:
  - Weakness:
  - Incoordination:
  - Loss of balance:
  - Loss of vision:
  - Loss of smell:
  - Loss of taste:
  - Difficulty swallowing:
  - Difficulty breathing:
  - Difficulty walking:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:
  - Difficulty using face:
  - Difficulty using mouth:
  - Difficulty using arms:
  - Difficulty using legs:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:
  - Difficulty using face:
  - Difficulty using mouth:
  - Difficulty using arms:
  - Difficulty using legs:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:
  - Difficulty using face:
  - Difficulty using mouth:
  - Difficulty using arms:
  - Difficulty using legs:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:
  - Difficulty using face:
  - Difficulty using mouth:
  - Difficulty using arms:
  - Difficulty using legs:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:
  - Difficulty using face:
  - Difficulty using mouth:
  - Difficulty using arms:
  - Difficulty using legs:
  - Difficulty using hands:
  - Difficulty using feet:
  - Difficulty using body:

- **Medical Team Use Only:**
  - [ ] Name:
  - [ ] Date:
  - [ ] Reviewed and Authorized by:
  - [ ] Signature:
<table>
<thead>
<tr>
<th>Evaluation and Readiness Codes:</th>
<th>□ Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Advance Directive</td>
<td></td>
</tr>
<tr>
<td>□ Access Community Resources</td>
<td></td>
</tr>
<tr>
<td>□ Referral</td>
<td></td>
</tr>
<tr>
<td>□ Use of Healthcare</td>
<td></td>
</tr>
<tr>
<td>□ Food / Drink Interactions</td>
<td></td>
</tr>
<tr>
<td>□ Use of Medications</td>
<td></td>
</tr>
<tr>
<td>□ Nutrition / Diet</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level Code</th>
<th>Patient Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Emotional: □ Yes □ No | Physical: □ Yes □ No |
| Vision: □ Yes □ No | Hearing: □ Yes □ No |

Do you have better words to teach? Please list:

Are there any cultural/philosophical practices you would like us to know about? □ Yes □ No

Preferred Language: □ English □ Other

Do you prefer to learn by: □ Seeing (pictures/video tape/white) □ Hearing (audiotape, verbal cues)

Initial Learning Needs Assessment:

Patient Family Education

Community: □ Other

Follow-up: □ Given Patient Discharge □ Refer to: [ ]

Did Parent(s) Comment: I 2 3 4 5 6 7 8 9 10

I Do you have any pain? □ Yes □ No (please specify in question 4)

Diagnosis: [ ]

Ambulatory Progress Note

Stony Brook Medicine
### Learning Needs Assessment

<table>
<thead>
<tr>
<th>Do any of the following apply for you?</th>
<th>Learning Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired Vision</td>
<td>How do you prefer to learn?</td>
</tr>
<tr>
<td>Impaired Hearing</td>
<td>Reading</td>
</tr>
<tr>
<td>Impaired or Speaking Problems</td>
<td>Person explaining to me</td>
</tr>
<tr>
<td>Pain</td>
<td>Seeing pictures</td>
</tr>
<tr>
<td>Concerns about your illness</td>
<td>People would like to have with you during your teaching?</td>
</tr>
<tr>
<td>None of the above</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you have difficulty understanding English?</th>
<th>Can you read English?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Is there anything about your beliefs or culture that would be important for us to know to provide you health care?**

**Learning Preferences:**
- 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

**Patient/Designee Signature:**

**Practitioner Signature:**

**Date:**

**ID #:**
Thank you.

1. Do your child ever wake up frequently at night?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

2. Have you ever seen your child stop breathing during sleep?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

3. Does your child have a problem with snoring during the day?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

4. Does your child wake up with headaches in the morning?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

5. Has a teacher or other supervisor commented that your child appears sleepy during the day?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

6. Is it hard to wake your child up in the morning?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

7. Does your child wake up with headache in the morning?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

8. Did your child stop growing at a normal rate at any time since birth?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

9. Is your child overweight?
   - Yes (Y)
   - No (N)
   - Don't know (DK)

10. This child often:
    - Occasionaly wet the bed?
       - Yes (Y)
       - No (N)
       - Don't know (DK)

Date: ____________________________
Person Completing Form: ____________________________
Study ID#: ____________________________
Child's Name: ____________________________

Pediatric Sleep Questionnaire: Sleep-Disordered Breathing Subscale