## Clinical Services Intake Checklist

*Please complete and include all of the following forms (included in this document):*

☐ CDD Clinical Services Intake Form

☐ UNMMG Consent to Treat - signed by legal guardian

☐ "About Me" Form

☐ UNMMG Telehealth consent forms

*If you have any screening reports, please include copies with intake.*

☐ Vision Screening
☐ Hearing Screening
☐ Developmental Screening (e.g., ASQ, SWIC)
☐ Autism Screening (e.g., M-CHAT-R/F)

**How do I return completed forms?**

Mail: Early Childhood Evaluation Program
UNM Center for Development and Disability
2300 Menaul Blvd NE
Albuquerque, NM 87107

Fax: 505-272-0685

E-mail: Early Childhood Evaluation Program at (505) 272-9846 for help with secure (encrypted) email communication.

*Please call the Early Childhood Evaluation Program, at (505) 272-9846 if you have any questions about evaluation services or this intake packet.*

## CDD Clinical Services Intake

Full name _____ Date of birth _____ Sex _____

Primary language _____ Other languages _____

Date completed _____ Referred by _____

**Current or most recent medical provider or pediatrician:**

| Provider Name / Practice | Mailing address | Phone/Fax |
|---|---|---|
| | | *Phone* |
| | | *Fax* |

**Insurance Information**

*Medicaid coverage?* ☐ *Yes /No* ☐ Medicaid #: _____

*Other insurance coverage?* ☐ *Yes /No* ☐ Insurance company: _____

Group #: _____ Policy #: _____

**Parents/Caregivers:** *Include adults that CDD staff can contact about this referral.*

| | | | | | |
|---|---|---|---|---|---|
| Name | | | Name | | |
| Relationship | | *Legal guardian* ☐ | Relationship | | *Legal guardian* ☐ |
| Primary Language | | | Primary Language | | |
| Mailing address | | | Mailing address | | |
| | | | | | |
| Phone numbers | | | Phone numbers | | |
| | | | | | |
| E-mail | | | E-mail | | |
| | | | | | |
| Name | | | Name | | |
| Relationship | | *Legal guardian* ☐ | Relationship | | *Legal guardian* ☐ |
| Primary Language | | | Primary Language | | |
| Mailing address | | | Mailing address | | |
| | | | | | |
| Phone numbers | | | Phone numbers | | |
| | | | | | |
| E-mail | | | E-mail | | |

Is child in Children, Youth, and Families Department or other protective custody? Yes ☐ No ☐

*If yes, have CYFD worker sign all consents and release forms.*

| CYFD Social Worker/contact | *Phone* | *Email* | *Fax* |
|---|---|---|---|
| | | | |

**Intervention or educational services: Include past and/or current EI, school, and other services such as speech-language (SLP) or occupational therapy (OT)**

(*Early Intervention: list **both*** Family Service Coordinator (FSC) and lead provider.)

| Provider/Agency Name | Services | Dates | Contact Information |
|---|---|---|---|
| | | | *Phone* |
| | | | *Fax* |
| | | | *E-mail* |
| | | | *Phone* |
| | | | *Fax* |
| | | | *E-mail* |
| | | | *Phone* |
| | | | *Fax* |
| | | | *E-mail* |
| | | | *Phone* |
| | | | *Fax* |
| | | | *E-mail* |

**Reason for Referral**

| *Check all that apply.* | *Please explain.* |
|---|---|
| ☐ **Autism Spectrum Disorder (ASD)** | |
| ☐ **Developmental** | |
| ☐ Medical | |
| ☐ Behavioral | |
| ☐ Family stressors | |
| ☐ Prenatal exposures/birth trauma | |

**Describe the purpose (your goals) for this evaluation:**

| |
|---|
| |

Has the child received services or evaluation from any UNM Center for Development and Disability (CDD) Program in the past?

| *Check all that apply:* | |
|---|---|
| ☐ Early Childhood Evaluation Program (ECEP/Developmental clinic) | ☐ Autism Parent Home Training |
| ☐ Autism Spectrum Evaluation Clinic | ☐ Child psychiatry (Dr. King) |
| ☐ Fetal Alcohol Spectrum Disorder or Prenatal Exposures Clinic | ☐ Neurodevelopmental Clinic |
| ☐ Neurocognitive Assessment Clinic | ☐ NM SAFE (Feeding) |

Does the child have a sibling diagnosed with autism spectrum disorder? ☐ Yes ☐ No
*If yes:* Sibling Name: _____ Date of Birth: _____
*Please include a copy of sibling's autism diagnostic evaluation report.*

**Developmental Milestones**

| When did the child first do the following? | *Age* | *Not yet* | *Not sure* |
|---|---|---|---|
| Sit without help | | | |
| Crawl on hands and knees | | | |
| Walk without help | | | |
| Say single words | | | |
| Combine two words | | | |
| Talk in short sentences | | | |
| Toilet trained: ☐ *daytime* ☐ *overnight* | | | |

**Previous diagnoses**

*Include any relevant medical, developmental, or behavioral diagnoses: e.g., seizure disorder, failure to thrive, ADHD, genetic syndromes, cerebral palsy, language disorder, anxiety disorder, etc.*

| Diagnosis | Date(s) | Provider (who made diagnosis?) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Center for Development and Disability
Consent to Treatment and Assignment of Benefits

1. I, the undersigned, hereby request and consent to medical treatment by the Center for Development and Disability or UNM Medical Group, Inc. and its physicians and staff (including administration of medication, tests and procedures) as deemed necessary.

2. I hereby assign and request payment directly to the Center for Development and Disability and UNM Medical Group, Inc. of any insurance or other authorized health benefits otherwise payable to me for medical treatment rendered, and to release any information required to the insurance company for consideration of payment for services.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient

# About Me

UNM | HEALTH SYSTEM

Your answers to these questions help us make sure we meet your needs and give the best, safest health care to **all** patients. Your answers will remain private. Access to this information is very restricted. Thank you!

**What name do you want us to call you?**

_____

**What is the sex on your original birth certificate?**

☐ Male ☐ Female

**Do you consider yourself Hispanic or Latino?**

☐ Yes ☐ No

☐ Don't want to answer

**What is your race?** (Pick One)

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander

☐ White or Anglo

**In what language do you prefer to <u>talk</u> about your health care?** (Pick One)

☐ English

☐ Spanish

☐ Vietnamese

☐ Navajo

☐ American Sign Language

☐ Other: _____

You have the right to a free interpreter. If needed, we'll provide one for you.

**In what language do you prefer to <u>read</u> about your health care?** (Pick One)

☐ English

☐ Spanish

☐ Vietnamese

☐ Other: _____

☐ I need help with reading

**If you are American Indian/ Native American, what tribe(s) or pueblo(s)?**

☐ Pueblo: _____

☐ Navajo

☐ Apache: _____

☐ Other: _____

**What is your spiritual preference?**

☐ Atheist

☐ Buddhist

☐ Catholic

☐ Christian or Protestant:

_____

☐ Jehovah's Witness

☐ Jewish

☐ Latter-Day Saints/Mormon

☐ Muslim

☐ Native: _____

☐ Sikh

☐ Spiritual

☐ Other: _____

☐ No Preference

**Thank you!**

If you have questions, please ask our staff.

patient label

# What You Need to Know about Telehealth

## What Is a Telehealth Visit?

A telehealth visit happens when you go to see your local provider. While you are there, the clinic uses a computer to connect to doctors and specialists at UNM in Albuquerque. The doctors at UNM might be connected with a live video and sound link. Or your provider might just send pictures and other information for those doctors to look at later.

This lets your provider work with doctors in other places to help you. But you don't have to travel to see them.

## Why Do I Need a Telehealth Visit?

Your provider thinks it would be helpful to work with a health care specialist. The telehealth visit will allow you and your provider to work with a specialist.

## How Can I Benefit?

- You can see a specialist who may help us understand your problem better.
- You might not need to go to Albuquerque.

## How Is My Privacy Protected?

Your privacy is protected just like in a face-to-face visit.

- What you and the doctors say and see in live video visits happens on a special secure computer system. This means no one else can see or hear what's happening.
- We will do our best to keep your visit and results private. The specialist will only speak to your local provider unless you agree otherwise.
- Telehealth visits are not recorded.

## What Are the Possible Risks?

- There could be problems with the computer connection. Then the UNM specialist may not be able to learn key things. Or the visit may have to be rescheduled.
- We are very careful to keep telehealth visits secure. But it is possible that our security could fail. If that happens, there is a chance your medical information may not stay private.

## What Are My Rights with Telehealth Visits?

- You can stop the visit at any time. You just need to say you want to stop.
- Sometimes images are taken for the specialist to look at later. You can decide after the visit that you don't want them sent.
- You don't have to have more telehealth visits if you don't want to, even if your doctor thinks it would be a good idea.
- Even if you don't want any more telehealth visits, you may still see your regular provider. You may also ask to see the UNM specialist for a face-to-face visit.
- You have the right to be told of everyone who is in the room at the UNM clinic during live video visits. You also have the right to know about anyone who needs to come into the room. For example, if there is a problem with the computer, a technical person may need to come in to fix it. If you want to, you may leave the room until that person is gone. You may also ask a person to leave if you want them to.
- Your local providers will tell you about any talks they have with the specialist at UNM.
- You have the right to a copy of your medical records. You can get a copy by following the regular steps at your clinic or hospital.

## What Else Should I Know?

- You or your insurance might be billed by UNM or your local provider for the visit. This will depend on agreements between your clinic and UNM. Ask your local clinic what to expect.
- Your local provider is still your main doctor. If you have an emergency or need to be seen right away, you should call your local provider.

# Patient Consent for Telehealth Services

UNM HEALTH SCIENCES CENTER

This form is to be used in addition to a consent for treatment appropriate to the service

Patient name _____ Date of birth _____

**I have been given a copy of the handout "What You Need to Know about Telehealth," and I understand what it says.**

**I have had a chance to ask questions and they have been answered.**

**When I sign this form, I am saying I understand and agree that:**

- the UNM health care specialist may discuss my medical history with my local provider.
- a provider at my local clinic may examine me as the UNM specialist guides him or her. The UNM specialist may also ask me questions through the video link.
- my medical information and images of my medical problems may be sent to the UNM specialist.

**By signing below, I agree to use telehealth as part of my health care.**

**Patient Sign Here**

Patient Sign Here _____ Date _____

## If patient cannot sign, person who can legally give consent for patient.

Printed name of Authorized Signer _____ Relationship to Patient _____

Signature of Authorized Signer _____ Date _____

Witness Printed Name _____ Signature of Witness _____ Date _____

Referring Provider _____ Location _____

Consulting Provider _____ Location _____

patient sticker

Please complete the following authorizations to request records from your:

- ☐ Birth Records
- ☐ Pediatrician/PCP
- ☐ Early Intervention
- ☐ Other Specialist(s)

Please include copies of any screening/prior testing reports with intake.

- ☐ IFSP/CME

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

**Patient Name:** _____ **Date of Birth**: _____ **Medical Record #**:_____

1. I hereby authorize _____ _____
(Name of Disclosing Party) (Phone/Fax of Disclosing Party)

_____
(Address, City, State, Zip of Disclosing Party)

To Disclose to:

☐ UNM Center for Reproductive Health
1701 Moon NE, Suite 200 Albuquerque, NM 87131
505-925-4455

☐ UNM Center for Life
4700 Jefferson Blvd. NE, Suite 100
Albuquerque, NM 87109
505-925-7464

☐ UNM Cardiology Clinic McMahon
4824 McMahon Blvd NW, Suite 109 Albuquerque, NM 87114
505-925-6001

☐ UNM Truman Health Services
801 Encino Place NE, Bldg F
Albuquerque, NM 87102
505-272-1312
**Please Fax Request to: 505-272-2240**

☑ UNM Center for Development and Disability
2300 Menual Blvd NE
Albuquerque, NM 87107
505-272-3000
**Please Fax Request to: 505-272-0685**

☐ UNM Vein and Cosmetic Center
7007 Wyoming Blvd NE, Suite A-3
Albuquerque, NM 87109
505-272-8346

☐ UNM Dental Services @ Camino de Salud Residency Clinic
1801 Camino de Salud, Suite 1200
Albuquerque, NM 87102
505-925-4031

☐ UNM Dental Services @ Camino de Salud Ambulatory Surgical Center
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505-925-7918

☐ UNM Dental Services @ Novitski Hall
2320 Tucker NE
Albuquerque, NM 87131
505-272-4106

☐ UNM Dental Services @ Carrie Tingley
1127 University Blvd,
NE Albuquerque, NM
87106 505-272-5326

2. Information to be disclosed:

☐ most recent visit/admission
☐ history & physical exam
☐ initial assessment
☐ consultation reports
☐ operative report
☐ discharge summary
☐ progress notes
☐ laboratory tests
☐ x-ray reports
☐ pathology reports
☐ ER record/outpatient log
☐ Billing
☐ school records
☐ psychological evaluation
☐ physical therapy evaluation
☐ speech & language evaluation
☐ occupational therapy

☐ Other (please specify) _____

Covering the period(s) of healthcare: from (date) _____ to (date) _____
from (date) _____ to (date)_____

**Patient Name:**_____ **Date of Birth**:_____ **Medical Record #**:_____

3. I further authorize that this disclosure of health information will include information relating to (initial if applicable): .
   a. acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, or other sexually transmitted diseases ____ initial
   b. behavioral health services/psychiatric care ____initial
   c. treatment for alcohol and/or drug abuse ____ initial
   d. genetic test results and related patient information ____ initial

4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: upon discharge. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

_____

Signature, Patient, or legal representative (Relationship to patient) (Date)

_____

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14)(Date)

**PROHIBITION OF REDISCLOSURE:** Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.

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Signature, Patient, or legal representative (Relationship to patient) (Date)

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4. I understand that I have a right to revoke this Authorization at any time. I understand that if I revoke this Authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: upon discharge. If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date on which it was signed.

5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

6. I understand that authorizing the disclosure of this health information is voluntary; that I can refuse to sign this Authorization and need not sign this Authorization to obtain health care treatment; and that if I authorize the disclosure of this health information, I have the right to examine and copy the information to be disclosed. A copy of this signed Authorization will be provided to me.

_____

Signature, Patient, or legal representative (Relationship to patient) (Date)

_____

Signature of Witness (Date) (Parent, if CPH/PFC&A patient over 14)(Date)

**PROHIBITION OF REDISCLOSURE:** Federal regulations (42 CFR Part 2) and State laws (NMSA 1978 §§ 43-1-19, 32A-6A-24, 24-2B-7 and 24-1-9.5) prohibit further disclosure of mental health or alcohol and/or drug abuse treatment information, and of the results of tests for HIV/AIDS and other sexually transmitted diseases to any person or agency without securing another proper written authorization for that purpose, or as otherwise permitted by Federal regulations or State laws.