CDD 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 NE Albuquerque NM 87107

Fax: Toll-free to (505) 272-2014

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.

Revised 2020.05.06 MBoehm

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 talk 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 read 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

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

CENTER FOR DEVELOPMENT & DISABILITY

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

UNM Center for Development and Disability
2300 Menual Blvd NE
Albuquerque, NM 87107
505-272-3000
Please Fax Request to: 505-272-2014

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

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

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

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

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

UNM Dental Services @ Camino de Salud Ambulatory Surgical Center
1801 Camino de Salud, Suite 1100
Albuquerque, NM 87102
505-925-7918

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:____________________________________. 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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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) ____

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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) ____

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CENTER FOR DEVELOPMENT & DISABILITY

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Other (please specify) ______________________________________

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