Children's Hospital of Richmond at VCU

Department of Pediatrics

Child Development Clinic
3600 W. Broad Street
Suite 115
Richmond, Virginia 23230

O 804.827.2100
F 804.827.2102
TDD 800.828.1120

Dear Parent/Guardian:

Thank you for your interest in the Child Development Clinic (CDC) at Children's Hospital of Richmond at VCU. Please complete the attached paperwork in order to continue the intake process. The following is a three-step process to setting up your appointment;

1) **Please contact 804-828-CHOR (2467) to register as a new patient if you are not already registered in the system.**
2) **Please complete the following intake packet.**
3) **Once the intake paperwork is complete return all requested information to the CDC at the address below. In addition, please send copies of any records (e.g. school records, previous psychological and/or educational testing) you would like reviewed.**

(Please be mindful that individuals are not considered for appointment time slots until packets are received and reviewed by the clinic)

Families will receive a confirmation letter after the intake packet has been received. If you have not received a confirmation letter within three weeks of mailing in the packet, please contact our offices at 804-827-2100. As a result of this process, a comprehensive developmental evaluation with one of our developmental providers will occur at your child's initial evaluation. If additional testing is recommended, it will be discussed at this initial visit.

The CDC must receive your completed intake paperwork prior to your child being considered for an appointment time. Again, we will send you a letter to confirm receipt of your paperwork. If you do not receive the letter within three weeks of the date you mailed your intake paperwork, please contact our office.

We look forward to seeing you soon.

Sincerely,

Child Development Clinic
Children's Hospital of Richmond at VCU

Enclosed:
(1) CDC Intake Packet

Please mail all intake paperwork to this address:

Child Development Clinic

3600 West Broad Street, Suite 115

Richmond, VA 23230

Please retain this letter for your records.

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Child Development Clinic (CDC) Intake Packet

Name of Child:	MRN:
Date of Birth: _____	Sex assigned at birth: ☐ Female Male Intersex Pronouns: _____ ☐ N/A
Address where child resides: Street: _____	City, State, Zip: _____
Primary language spoken at home: _____ Other language(s) spoken:	

Person Completing this Form

Name(s):	
Relationship to Child (e.g., Mother/Father/Foster Parent/Grandparent/Legal Guardian etc.):	
Street Address:	
City, State:	County (if applicable):
Zip Code:	
Phone:	Email:

Current School Information

School/Daycare:			Grade:	
City/County:				
Services: IEP	504 Plan	Speech	OT	PT
Date of IEP:	Date of 504:	Other _____		

Service History

Early Intervention or Rural Infant Services Program (RISP) (please list services): Location:
Other services (therapy, ABA, etc.):
Has your child previously participated in developmental evaluation? Yes No If yes, when and where (please send copy for review) _____

Medical Information

Primary Care Provider:	Phone:
Did your Primary Care Provider refer you to the VCU CDC? Yes	No
Referring Provider (if different from above):	
Previous Diagnoses (medical, psychological, educational) :	
Medications and Dosages:	

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What questions would you like this evaluation to answer?

Primary Concerns

I am concerned about my child's ***(please check all that are relevant, and list any additional concerns on the lines below):***

□ Impulsivity and/or Hyperactivity □ Short attention span □ Restlessness □ Concentration □ Organizational skills	□ Depression □ Anxiety/fears □ Anger □ Irritability □ Self-regulation □ Low self-esteem □ Sadness □ Mood swings □ Self Stimulation (rocking, head banging, etc.)	□ Tantrums/ meltdowns □ Verbal or physical aggression □ Defiance □ Bullying others □ Unusual sexual activity □ Property damage □ Vandalism □ Resists change □ Repetitive or restrictive patterns of behaviors	□ Falling asleep □ Staying asleep □ Nightmares □ Restlessness □ Grinding teeth □ Sleepwalking □ Night Terrors □ Falls out of bed
□ Listening or Awareness □ Comprehension or Processing □ Fine or Gross Motor skills □ Speech (ex. nonverbal, speech delay) □ Hand "flapping" □ "Toe Walking" □ Feeding behaviors	□ Relationships with others □ Limited social skills/interactions □ Appears indifferent □ Lack of response to name being called □ Limited eye contact □ Aversion to noise	□ Reasoning/problem solving □ Ability to learn/ trouble in school or daycare □ Limited imitation of sound, words or patterns □ Difficulty with alphabets, numbers and/or writing	□ Limited sense of danger □ Non-responsive to pain □ Transition to adulthood □ Safety (ex. elopement, non-injurious self-harm, suicidal ideation)

Other:_____

_____

Presenting Strengths

(What is your child currently good at?)

_____

_____

_____

Have there been any major changes in your child's life in the past 2 years?
(e.g., moves, financial changes, divorce/separations, health issues, death of family member, traumatic events etc.)

_____

_____

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Developmental Milestones

Please note an approximate age in which your child accomplished the following task with consistency:

Task:	Age: N/A	Task:	Age: N/A
Rolled Over	months: _____	Smiled	months: _____
Sat w/ support	months: _____	Babbled	months: _____
Crawled	months: _____	Said first word	months: _____
Walked	months: _____	Used two-word phrases	months: _____
Ran	months: _____	Followed one-step commands	months: _____
		Pointed to pictures	months: _____
		Acknowledged body parts	months: _____
		Stated full name	years: _____
		Stated age	years: _____
Task:	Age: N/A	Task:	Age: N/A
Reached for small objects	months: _____	Followed your gaze	months: _____
Finger fed self	months: _____	Pointed to request object	months: _____
Drank from cup	months: _____	Brought you an object	months: _____
Fed self with spoon	months: _____	Pointed to show interest	months: _____
Undressed self	years: _____	Engaged in pretend play	years: _____
Dressed self	years: _____		
Potty trained	years: _____		

Family History

Please note if any biological family members of the child have any of the following, check all that apply:

	Mother	*Father*	*Sibling*	*Other*
Intellectual or Learning Disability				
Seizures				
ADHD or ADD				
Speech & Language Delay				
Autism Spectrum Disorder				
Depression				
Anxiety				
Post-Traumatic Stress Disorder (PTSD)				
Bipolar Disorder or Schizophrenia				
Substance Use Disorder				
Thyroid Problems				
Heart Disease				
Cancer				
Diabetes				
Other (Please Specify):				

Please mail the completed Intake Packet to the VCU CDC.

Please include: **(1) Intake Form & (2) Copies of previous evaluations or testing**