Children's Hospital of Richmond at VCU

Department of Pediatrics

Child Development Clinic
2924 Brook Rd.
Richmond, Virginia 23220

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

2924 Brook Road

Richmond, VA 23220

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___ Date of IEP:	504 Plan ___ Date of 504:	Speech___	OT___	PT___ 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**