Le Bonheur On the Move: Mobile Medical Unit
Consent for Medical Examination and Care
June 2016 – July 2017

Dear Parent/Guardian,
During the year as identified above, your child will have the opportunity to receive annual (or sports) physicals and medical care including sick visits provided by a Le Bonheur provider right at your child's school/community site. The care will be provided on Le Bonheur's state of the art Mobile Medical Unit or at a designated site. There is no need for you to be present when your child is on the mobile unit, but we invite you to be present anytime your child is being seen.

In order for your child to participate in this program, you will need to sign this consent form and complete the information in this booklet. We will be scheduling children for annual (or sports) physicals starting with those that are uninsured or underinsured.

Children will be seen on the mobile unit regardless of their ability to pay for services provided. Insurance will be filed when available. Please complete all of the information in this booklet to allow us to provide the best care for your child and to bill your insurance provider, if necessary.

Please read the following statements related to care provided on the mobile unit.

CONSENT TO EVALUATE AND PROVIDE TREATMENT FOR THE CONSENT YEAR AS IDENTIFIED ABOVE

I give permission for my child to receive a medical examination by a physician or nurse practitioner of Le Bonheur Mobile Medical Unit for the purpose of evaluation and/or treatment of medical conditions as well as routine health maintenance. All medical examinations are overseen by a board certified physician or nurse practitioner. I understand that I must give my consent on this form in order to receive medical evaluation and/or treatment. Medical evaluation includes obtaining test results from blood tests, urine tests, saliva tests, and/or other medical tests as required by the physician or nurse practitioner. According to the guidelines established by the American Academy of Pediatrics, all EPSDT/Wellness exams will be unclothed. A drape/gown will be provided and children will keep on their undergarments. The child's privacy will be protected at all times and two healthcare professionals will be present during the unclothed exam for your child's protection.

RELEASE OF INFORMATION AND CONSENT FOR FOLLOW-UP

I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to receive relevant information about my child's health from a doctor's office, clinic, school, or agency from which additional information may need to be gathered. I also authorize release of information about my child's health to a doctor's office, clinic, school, or agency to which he/she may be referred. I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to contact me by telephone or mail regarding the results of my child's exam, possible care options, tips for improving my child's health, specialist appointments, and/or other health related topics. I give permission for my child to be involved in case management activities (such as individual and group meetings) offered after the initial clinic visit. I authorize Le Bonheur Mobile Medical Unit to leave a message regarding appointment or test at my residence or cell phone. I authorize Le Bonheur Mobile Medical Unit to send appointment reminders or other reminders via text message or automated voice message. It is my responsibility to provide Le Bonheur the most up to date contact information. I authorize for my child to have a photo taken for the electronic medical record. I authorize Le Bonheur to electronically access my prescription history through RX Hub (a prescription database compiling all prescription history).

SHARING INFORMATION WITH PARENTS/GUARDIANS

Le Bonheur Mobile Medical Unit follows state regulations and American Academy of Pediatric guidelines regarding adolescent care, adolescent age of consent for medical care, and parent/guardian notification for medical treatment. Adolescent patients will be encouraged to maintain open communication with parents. However, Le Bonheur Mobile Medical Unit will disclose medical information according to Tennessee state law. Please contact Le Bonheur with any questions about age of consent or release of information.

DATA COLLECTION

I understand information about my child's progress may be used by Le Bonheur for data collection and reporting purposes. I understand my child's name will not be used without my permission. Le Bonheur Community Health and Well-Being, Le Bonheur Mobile Medical Unit, and their affiliates are hereby released from all legal liability that may arise from the release of the information or from the publication of data obtained.

Patient Name: _____ **DOB:** _____

NOTICE OF PRIVACY PROCEDURES (HIPPA)
I have received a copy of the "Notice of Privacy Procedures" for Le Bonheur, in compliance with HIPAA regulations.

NOTIFICATION OF GRIEVANCE PROCEDURE
I understand that if I believe either I or my child has been treated unfairly during the course of this screening because of my gender, race, color, national origin, religion, or disability, I have the right to file a complaint. Such complaints are to be addressed in writing to Le Bonheur, Director of Health Services, 77 Stonebridge Boulevard, Jackson, TN 38305. More information may be obtained by calling Le Bonheur at 731-984-9961.

CONSENT TO BILL THIRD PARTY PAYOR (INSURANCE)
I authorize University Le Bonheur Pediatric Specialists, Inc., Le Bonheur Children's Hospital, Le Bonheur Community Health and Well-Being, and or their affiliates, to release any information pertaining to treatment to enable the collection of insurance benefits for the services rendered. Release of information is also authorized to any providers of follow-up medical care.

I understand and agree that this consent is valid during the consent year as the term identified above unless I cancel it in writing. To the best of my knowledge the information provided is complete and correct. I understand it is my responsibility to inform Le Bonheur and its staff if I or my child/ward, has a change in health, insurance coverage or contact information,

For more information, please contact Le Bonheur Mobile Health at:
731-984-9961 (Direct Line)

_____ _____
Signature of Parent/Guardian Date

PARENT/GUARDIAN INFORMATION

Name:_____ DOB:_____SS#:_____
Last First MI

Parent/Guardian Email: _____

Relationship to Patient: _____ Phone Number for Parent/Guardian:_____

Questions About Your Child's Health Care Provider

Has your child visited the doctor or health care provider because he/she was sick in the last 12 months? ☐ Yes ☐ No ☐ I don't know.

Reason:_____

Who is your child's doctor or health care provider?_____Phone:_____

Who is your preferred pharmacy?_____Phone:_____

Patient Name: _____ **DOB:** _____

Insurance Information

Primary Insurance Information:

- ☐ Private Insurance (Other:_____)
- ☐ BlueCare (TennCare)
- ☐ United Community Health Plan (TennCare)
- ☐ Amerigroup (TennCare)
- ☐ CoverKids (TennCare)
- ☐ My child is uninsured.

Member ID Number:_____ Group ID Number:_____

Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder SS#:_____

Secondary Insurance Information:

- ☐ Private Insurance (Other:_____)
- ☐ BlueCare (TennCare)
- ☐ United Community Health Plan
- ☐ Amerigroup (TennCare)
- ☐ CoverKids
- ☐ My child is uninsured.

Member ID Number:_____ Group ID Number:_____

Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder SS#:_____

Health Questions

Child's Name:_____ Age:_____ Sex: M F
First Middle Last

School:_____ Phone Number for Parent/Guardian:_____

Child's Date of Birth:_____ Child's Social Security Number:_____
Mo. Day Year

Address of Child:_____
Street Address P.O. Box City State Zip

Child's Race/Ethnicity: ☐ Black ☐ Hispanic ☐ White ☐ Other:

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Other:

Family Medical History (Please mark any of the following medical conditions that members of your child's family have.)

Child's Mother: ☐ Living ☐ deceased

☐ High Cholesterol ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Stroke

☐ Mental Illness ☐ Cancer ☐ Heart Attack (Under the Age of 55) ☐ Other Medical Conditions:_____

Does the mother take cholesterol medication? ☐ Yes ☐ No

Child's Father: ☐ Living ☐ deceased

☐ High Cholesterol ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Stroke

☐ Mental Illness ☐ Cancer ☐ Heart Attack (Under the Age of 55) ☐ Other Medical Conditions:_____

Does the father take cholesterol medication? ☐ Yes ☐ No

Child's Grandparent: ☐ High Cholesterol ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Stroke

☐ Mental Illness ☐ Cancer ☐ Heart Attack (Under the Age of 55) ☐ Other Medical Conditions:_____

Child's Medical History (please mark any of the following medical conditions that apply to your child)

☐ ADHD/ADD ☐ Congenital Heart Disease ☐ Diabetes ☐ Asthma ☐ Kidney Disease ☐ Elevated Blood Pressure

☐ Other Medical Conditions:_____

Has your child ever required hospitalization? ☐ Yes ☐ No Reason: _____ Date_____

Has your child had any surgical procedures? ☐ Yes ☐ No Reason: _____ Date_____

Please list all medications the child is currently taking. ☐ **No Medications** Include all prescription and nonprescription medication.
1._____
2._____
3._____
4._____
5._____

Please list any allergies your child has. ☐ **No Allergies**
1._____
2._____
3._____
4._____
5._____

Is your child current on all immunizations and vaccinations? ☐ Yes ☐ No ☐ I don't know.

Is your child having any problems, or are you having any concerns?_____

_____

Ages and Stages Questionnaire
Overall Developmental Screening

Ages: Birth – 5 Years

Child's Name:_____ Child's School:_____

Please answer the following questions and explain any details that you feel are important.

1. Do you think your child hears well?	☐ Yes ☐ No	If no, explain:
2. Do you think your child talks like other children her age?	☐ Yes ☐ No	If no, explain:
3. Can you understand most of what your child says?	☐ Yes ☐ No	If no, explain:
4. Do you think your child walks, runs, and climbs like other children his age?	☐ Yes ☐ No	If no, explain:
5. Does either parent have a family history of childhood deafness or hearing impairment?	☐ Yes ☐ No	If yes, explain:
6. Do you have any concerns about your child's vision?	☐ Yes ☐ No	If yes, explain:
7. Has your child had any medical problems in the last several months?	☐ Yes ☐ No	If yes, explain:
8. Does anything about your child worry you?	☐ Yes ☐ No	If yes, explain:

Pediatric Symptom Questionnaire Checklist 17 (PSC-17)

Ages: 6 – 20 Years

Child's Name:_____ Child's School:_____

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

Please mark under the heading that best describes your child:

	Never	Sometimes	Often
* Fidgety, unable to sit still.			
□ Feels sad, unhappy			
* Daydreams too much			
● Refuses to share			
● Does not understand other people's feelings			
□ Feels hopeless			
* Has trouble concentrating			
● Fights with other children			
□ Is down on him or herself			
● Blames others for his or her troubles			
□ Seems to be having less fun			
● Does not listen to rules			
* Acts as if driven by a motor			
● Teases others			
□ Worries a lot			
● Takes things that do not belong to him or her			
* Distracted easily			

Do you have any concerns regarding your child's behavior, emotions, or learning?_____

_____

OFFICE USE ONLY

Total (*) _____ Total (●) _____ Total (□) _____ * + ● + □ =_____

If your child has asthma, please complete the following section:

Questionnaire for Patients with Asthma

Child's Name:_____ Child's School:_____

Please answer the following questions about your child's asthma symptoms:

Has your child been diagnosed with asthma by a nurse practitioner or doctor? If Yes, when:	☐ Yes ☐ No
Has your child been having asthma symptoms this week?	☐ Yes ☐ No
Does anyone smoke inside your home?	☐ Yes ☐ No
Do you think your child uses tobacco products?	☐ Yes ☐ No
Does your child have any exercise or activity limitations due to asthma?	☐ none ☐ minor limitations ☐ some limitations ☐ extremely limited
Has your child been prescribed an asthma controller medication? (ex. Pulmocort, Singulair, Flovent, etc.)	☐ Yes ☐ No
Is your child using the asthma controller medication? If not, why? (ex. Pulmocort, Singulair, Flovent, etc.)	☐ Yes ☐ No
How many times per week did your child use a **rescue medication** in the past 4 weeks? (ex. Albuterol, inhaler, etc.)	☐ ≤ 2 days/week ☐ > 2 days/week ☐ > 1 time/day
How often did the patient have **daytime** asthma symptoms for the past 4 weeks?	☐ ≤ 2 days/week ☐ > 2 days/week ☐ daily ☐ > 1 time/day
How often did the patient **awake at night** with asthma symptoms this past 4 weeks?	☐ 0 nights/month ☐ 1-2 nights/month ☐ 3-4 nights/month ☐ > 1 night/week
How many times in the past 12 months has the patient had to take oral steroids?	
Has your child seen a provider for asthma symptoms during the past 12 months?	☐ Yes ☐ No # of Visits:
Has your child visited the emergency room for asthma symptoms during the past 12 months?	☐ Yes ☐ No # of Visits:
Has your child missed school for asthma symptoms during the past 12 months?	☐ Yes ☐ No # of Days:
Has your child been admitted to the hospital for asthma symptoms during the past 12 months?	☐ Yes ☐ No # of Times: