DOS

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

UK Pediatric Therapies at Child Development Center of the Bluegrass

MEDICAL HISTORY and PEER MODEL CONSENT FORM

(Patient Label Here)

I am requesting services for my child in: ☐ OT ☐ PT ☐ SLP

Child's Name: _____ Date of Birth: _____

Child's Gender: Male Female Child's Diagnosis: _____

Child's Address: _____
(Street) (City) (Zip)

Child is in the custody of: _____ Child resides with: _____

Mother's Name: _____ Father's Name: _____

Mother's Contact Number: _____ Father's Contact Number: _____

Mother's Email Address: _____ Father's Email Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email Preferred Method of Contact: ☐ Phone ☐ Email

Medical History

Was your child full term? _____ If not, how premature? _____

Has your child had any significant illnesses? _____ If yes, explain: _____

Does your child have any allergies? _____ If yes, explain: _____

Has your child ever been hospitalized? _____ If yes, explain: _____

_____

Has your child had any surgeries? _____ If yes, please list type and date of surgery: _____

_____

Is your child currently taking any medications? _____ If yes, please list: _____

_____

HealthCare

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MEDICAL HISTORY and PEER MODEL CONSENT (cont.)

(Patient Label Here) _____

Does your child struggle with any of the following? (Please mark all that apply.)

☐ Feeding Difficulties	☐ Sleep Difficulties	☐ Tripping / Falling
☐ Behavioral Concerns	☐ Reflux	☐ Attention and / or following directions
☐ Fine Motor / Handwriting	☐ Peer Interaction	☐ Communicating with peers and / or caregivers

What is your primary concern? _____

_____

What are your child's strengths / interests? _____

_____

Has your child been examined by any of the following:

Specialist	Date	Results	Diagnosis
Allergist			
Audiologist			
Cardiologist			
Dentist			
Developmental Pediatrician			
Geneticist			
Ophthalmologist			
Otolaryngologist (ENT)			
Neurologist			
Occupational Therapist			
Physical Therapist			
Psychiatrist			
Psychologist			
Speech Language Pathologist			
Developmental Interventionists			
Other			

List any other concerns you would like your child's therapist(s) to know: _____

_____

_____

Peer Consent: I give permission for my child to interact with a peer model during therapy sessions (PT, OT, SLP). The peer model will be another child enrolled at Child Development Center of the Bluegrass. The purpose of integrating a peer model is to enhance participation in the therapy session. ☐ Yes ☐ No, thank you.

Completed by: _____ Date: _____

Relationship to child: _____

Reviewed by: _____ Date / Time: _____