GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

BEFORE YOU START PLEASE READ THE FOLLOWING INSTRUCTIONS

Enclosed is important information that needs to be completed to help diagnose and treat your child. Our office does not diagnose ADD or ADHD, however we do treat and maintain medicine.

In this packet you will find a list of child Psychologist and Psychiatrists that will perform psycho-educational evaluations. Making the appointment with one of the doctors on the list is the first step of many in order to have your child diagnosed and treated for ADD or ADHD. The psycho-educational testing MUST be completed by a psychologist and a report of that visit should be sent to out office before scheduling any appointments with our doctors. This should be mailed or faxed to the office your child goes to. It is recommended to keep a copy of the evaluation for your records.

601-A Professional Drive Suite 370
Lawrenceville, GA 30046
Fax: 770-995-7018

2089 Teron Trace Suite 100
Dacula, GA 30019
Fax: 770-831-7285

4700 Nelson Brogdon Blvd Suite 180
Sugar Hill, GA 30518
Fax: 678-765-3301

3855 Pleasant Hill Rd. Suite 210
Duluth, GA 30096
Fax: 770-476-0947

There are three forms to be completed in this packet. Please send these forms with your psycho-evaluation report to the office.

1. ADHD Intake form – To be completed by parent
2. Vanderbilt- To be completed by parent
3. Vanderbilt- To be completed by child's teacher. If child has more than one teacher, please have it completed by the teacher who spends the most time with your child.

Please feel free to bring any additional information (psycho-educational testing, test scores, school report cards, school work, etc.) that may be helpful.

ADD/ADHD Consultation Check off List

- ☐ Call the Psychologist or Psychiatrist and set up psycho-educational testing.
- ☐ Have psycho-educational testing report sent to Beverly.
- ☐ Complete “ADD Evaluation Form”
- ☐ Complete “Vanderbilt Parent Form’
- ☐ Have teachers complete “Vanderbilt Teacher Form”
- ☐ Return entire completed packet to the office. (Mail or Fax)

Once all of the above steps are completed we will have our doctor review the packet and call you to set up the appointment.
If you need further instructions please contact a scheduler at 770-995-0823 option 1.

PSYCHOLOGIST-PSYCHO EDUCATIONAL TESTING

**This is our recommended list. You do not have to use these providers, you may contact your insurance provider if you wish to find a doctor your insurance covers.

Dr. Shirley Boone-Sanford
195 West Pike St. 207 Lawrenceville, GA 30046
2078 Teron Trace Ste 250 Dacula GA 30019
678-205-0838
www.healgrowempower.com

Dr. Erin Floyd, Karen Dean
1805 Herrington Rd. Bld 2 Lawrenceville, GA 30043
770-962-1944
www.erinfloydphd.mysite.com

Dr. Matt Turner Kid Psychologist, LLC
1805 Herrington Rd Bld 2 Lawrenceville, GA 30043
678-524-6005
www.kidspsychologist.com

Dr. Judy Kerley, Dr. Mary Grace Thomas
4411 Suwanee Dam Road Ste 920 Suwanee 30024
678-714-9590

Dr. Saori Maruyama
10475 Medlcok Bridge Rd Bld 300 Ste 315 Johns Creek, GA 30097
678-369-3837
www.johnscreekpsychology.com

Dr. Spomenka Newman
1010 North Main Street Stone Mountain, GA 30083
770-315-4554
www.psychologist4kids.com

Psychological Solutions of North Atlanta
6290 Abbotts Bridge Rd Ste 501 Duluth, GA 30097
404-202-1309
www.psychsolutionsna.com

Dr. Craig Kerley
3949 Holcomb Bridge Road Ste 202 Norcross GA 30092
770-449-0082
www.drkerley.com

Atlanta Pediatric Psychology Associates
3589 Habersham at Northlake Tucker, GA 30084
770-939-4473
www.appanorthlake.com

Atlanta Area Psychological Associates, P.C
327 Dahlonega Street Suite 1801-B Cumming, Georgia 30040

770-953-6401

G P A M

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

Date:

Attention Deficit Disorder Intake Form:

Patient:
DOB:
Age:
Grade:

Was your child born premature or at term? If premature, how early?	YES	NO
Were there any complications with the pregnancy or delivery of your child? If so, please describe:	YES	NO
Does your child have any problems with sleep such as snoring, poor quality, frequent nightmares or trouble initiating sleep? If so please describe:		
Does your child have a difficult temperament (i.e. had colic, lots of tantrums, picky eating, troubles with babysitters, etc?)	YES	NO
Has your child ever needed speech therapy, physical therapy or occupational therapy? If so please describe.	YES	NO
Have you ever been concerned that your child might seriously harm his/herself or someone else?	YES	NO
Has your child ever heard voices that weren't there, described visions that didn't exist?	YES	NO
Have you ever sought psychological counseling for your child?	YES	NO
Has your child had conflict with teachers, staff or peers at school?	YES	NO
Has your child ever been suspended from school?	YES	NO
Has there ever been discussion regarding repeating a grade at school?	YES	NO
Has your child ever had an Individualized Education Plan (IEP)?	YES	NO

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

Has your child had a history of:

Learning problems?	YES	NO
Serious head injury?	YES	NO
Loss of consciousness?	YES	NO
Meningitis?	YES	NO
Seizures?	YES	NO
Staring Spells?	YES	NO
Tics?	YES	NO
Depression?	YES	NO
Recurrent headaches?	YES	NO
Recurrent abdominal pain?	YES	NO

If you answered yes to any of the above questions, please describe here:_____
_____
_____
_____
_____

Please list any medications, including vitamins and herbal supplements, that your child currently takes._____
_____

Please circle any of the following that occur in your family:
Attention Deficit Disorder
Mental Illness
Drug or Alcohol Abuse
Neurological disorder
Learning/reading difficulties
Birth defects
Trouble with the criminal justice system
Physical or sexual abuse
Thyroid disease
Toxic exposures (e.g. Lead, mercury)
If you circled any of the above conditions, please describe here:_____
_____
_____
_____
_____

Who lives in your home?
_____
_____

Pediatric Cardiac Risk Assessment Form

Complete this form for each person under the age of 50, including children, periodically during well child visits including neonatal, preschool, before and during middle school, before and during high school, before college and every few years through adulthood. *If you answer "Yes" or "Unsure" to any questions, read the back of this form.*

Name:_____ **Age:**_____ **Date:**_____

Individual History Questions:	**Yes**	**No**	**Unsure**
Has this person fainted or passed out DURING exercise, emotion or startle?			
Has this person fainted or passed out AFTER exercise?			
Has this person had extreme fatigue associated with exercise (different from others of similar age)?			
Has this person ever had unusual or extreme shortness of breath during exercise?			
Has this person ever had discomfort, pain or pressure in his chest during exercise, or complained of his heart "racing or skipping beats"?			
Has a doctor ever told this person they have: □ high blood pressure □ high cholesterol □ a heart murmur or □ a heart infection? (Check which one, if any.)			
Has a doctor ever ordered a test for this person's heart? If yes, what test and when?			
Has this person ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma? If yes, which one and when?			
Has this person ever been diagnosed with any form of heart/cardiovascular disease? If yes, what was the diagnosis?			
Is this person adopted, or was an egg or sperm donor used for conception?			
Family History Questions (think of grandparents, parents, aunts, uncles, cousins and siblings):			
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (including SIDS, car accident, drowning, passing away in their sleep, or other)			
Are there any family members who died suddenly of "heart problems" before age 50?			
Are there any family members who have had unexplained fainting or seizures?			
Are there any family members who are disabled due to "heart problems" under the age of 50?			
Are there <u>any</u> relatives with certain conditions such as:			
Check the appropriate box: □ Hypertrophic cardiomyopathy (HCM) □ Dilated cardiomyopathy (DCM)			
Check the appropriate box: □ Arrhythmogenic right ventricular cardiomyopathy (ARVC), □ Long QT syndrome (LQTS), □ Short QT syndrome, □ Brugada syndrome, □ Catecholaminergic ventricular tachycardia			
Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger)			
Check the appropriate box: □ Aortic rupture or Marfan syndrome □ Ehlers-Danlos syndrome □ Primary pulmonary hypertension □ Congenital deafness (deaf at birth)			
□ Pacemaker or □ implanted cardiac defibrillator (if yes, whom and at what age was it implanted?)			
Other form of heart/cardiovascular disease or mitochondrial disease			
Has anyone in the family had genetic testing for a heart disease? If yes, for what disease? _____ Was a gene mutation found? Circle one: YES/NO			
Explain more about any "yes" answers here:			
Physical Exam from Physician should include: (to be performed by a physician – made available here for the purpose of parent/patient education to ensure all evaluations have been completed)			
Evaluation for heart murmur in both supine and standing position and during valsalva			
Femoral pulse			
Brachial artery blood pressure – taken in both arms			
Evaluation for Marfan syndrome stigmata			
<u>Turn form over if you answered "yes" or "unsure" to one or more questions</u>			

This form includes all items suggested in the American Heart Association Recommendations for Preparticipation Screening for Cardiovascular Abnormalities in Competitive Athletes– 2007 Update Circulation 2007:115

For more information, visit <u>www.choa.org/cardiology</u>, email <u>info@kidsheart.com</u> or call 404-256-2593 (800-542-2233).

Updated 11.21.2011

If you answered "yes" or "unsure" to one or more questions on this form, you may be wondering what to do next.

Step One – Contact your health care provider, normally your General Physician, Family Practitioner or Pediatrician and discuss the form. Talk about areas of risk you have identified and discuss having a full cardiac exam by a cardiac professional. Some physicians may be comfortable ordering cardiac testing and interpreting the results and some may not, therefore a referral may be needed to a cardiologist.

Step Two – Based upon your insurance provider, either ask your doctor for a referral for a complete cardiac evaluation by a cardiologist or seek the appointment on your own. This appointment should include basic cardiac testing based on the individual's history but normally includes a consult with the cardiologist, an electrocardiogram (ECG), echocardiogram (echo) and in some cases stress testing and additional cardiac imaging such as CT scans or cardiovascular magnetic resonance imaging (cMRI).

Step Three – Communicate your history to the rest of your family so they can seek appropriate screening.

Things you should know about additional testing for sudden cardiac arrest (SCA) risks:

1. Nearly all tests are painless, noninvasive and require no needles.
2. Tests are an evaluation of the heart at that moment in time and things may change over time, therefore you may need to repeat the testing on yourself or your child at intervals throughout life.
3. The knowledge of cardiac diseases that cause sudden cardiac arrest is evolving, and testing may change over time. The definition of normal or abnormal may also change.
4. If you and/or your loved one are found to be at risk for SCA, there are things you can do to help prevent SCA including:
    a. Taking medication
    b. Having an implantable cardioverter defibrillator (ICD) implanted (a pacemaker-like device that can provide a lifesaving shock if you experience SCA)
    c. Making lifestyle modifications to reduce risk (for example, some may need to refrain from *competitive* sports)

Special note: If you answered "unsure" to questions about health history, discuss the details with complete candor with your health care provider. Cases of adoption, egg or sperm donation, or uncertain paternity are areas of specific concern as the health information that may have been available at the time of adoption, donation or last contact with the father may have changed and you may be unaware. We suggest that you err on the side of caution and seek baseline cardiac testing in these cases.

For more information:
Call Sibley Heart Center Cardiology at 404-256-2593 or 800-542-2233
Email info@kidsheart.com
Visit www.choa.org/cardiology to print additional copies.

This form includes all items suggested in the American Heart Association Recommendations for Preparticipation Screening for Cardiovascular Abnormalities in Competitive Athletes– 2007 Update Circulation 2007:115

NICHQ Vanderbilt Assessment Scale – PARENT Informant*

Today's Date: _____ Child's Name: _____ Date of Birth:_____

Parent's Name: _____ Parent's Phone Number:_____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ❒ was on medication ❒ was not on medication ❒ not sure?

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2.	Has difficulty keeping attention to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7.	Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8.	Is easily distracted by noises or other stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat when remaining seated is expected	0	1	2	3
12.	Runs about or climbs too much when remaining seated is expected	0	1	2	3
13.	Has difficulty playing or beginning quiet play activities	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22.	Deliberately annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or resentful	0	1	2	3
26.	Is spiteful and wants to get even	0	1	2	3
27.	Bullies, threatens, or intimidates others	0	1	2	3
28.	Starts physical fights	0	1	2	3
29.	Lies to get out of trouble or to avoid obligations (i.e. "cons" others)	0	1	2	3
30.	Is truant from school (skips school) without permission	0	1	2	3
31.	Is physically cruel to people	0	1	2	3
32.	Has stolen things that have value	0	1	2	3
33.	Deliberately destroys others' property	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically cruel to animals	0	1	2	3
36.	Has deliberately set fires to cause damage	0	1	2	3

NICHQVanderbiltParent.20050602

NICHQ Vanderbilt Assessment Scale – PARENT Informant*

Today's Date: _____ Child's Name: _____ Date of Birth:_____

Parent's Name: _____ Parent's Phone Number:_____

	Symptoms	Never	Occasionally	Often	Very Often
37.	Has broken into someone else's home, business, or car	0	1	2	3
38	Has stayed out at night without permission	0	1	2	3
39.	Has run away from home overnight	0	1	2	3
40.	Has forced someone into sexual activity	0	1	2	3
41.	Is fearful, anxious, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels worthless or inferior	0	1	2	3
44.	Blames self for problems, feels guilty	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46.	Is sad, unhappy, or depressed	0	1	2	3
47.	Is self-conscious or easily embarrassed	0	1	2	3

	Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48.	Overall school performance	1	2	3	4	5
49.	Reading	1	2	3	4	5
50.	Writing	1	2	3	4	5
51.	Mathematics	1	2	3	4	5
52.	Relationship with parents	1	2	3	4	5
53.	Relationship with siblings	1	2	3	4	5
54.	Relationship with peers	1	2	3	4	5
55	Participation in organized activities (e.g. teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1-9: _____

Total number of questions scored 2 or 3 in questions 10-18: _____

Total Symptom Score for questions 1-18: _____

Total number of questions scored 2 or 3 in questions 19-26: _____

Total number of questions scored 2 or 3 in questions 27-40: _____

Total number of questions scored 2 or 3 in questions 41-47: _____

Total number of questions scored 4 or 5 in questions 48-55: _____

Average Performance Score: _____

NICHQVanderbiltParent.20050602

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____