Casa Care Pediatric Therapy, LLC

Screening Sign up Form

www.casacarept.com/casacarept@yahoo.com/704.892.8074

Gross Motor Screening

COMPLETE YOUR CHILD'S INFORMATION

Child's name _____ Birth date _____

Mother's name: _____

Father's name: _____

Legal Guardian/Custodian: _____

Address _____ City _____ State _____ Zip _____

Home phone _____ main home E-mail _____

Mother Cell _____ Father Cell _____

Current school/Daycare (if applicable) _____Academic level _____ Grade _____

Pediatrician/PCP practice: _____

Practice phone number: _____

Medications: _____

Dentist/Dental Practice: _____

Practice phone number: _____

How did you hear from us? _____

Appointment:

Preferred appointment time and day of week: _____

CASA CARE PEDIATRIC THERAPY, LLC POLICIES

NO FEE AGREEMENT:I have read and understand that today's appointment is not a formal evaluation but a motor screen of my child's performance to determine the need for a formal physical therapy, occupational therapy assessment and/or the participation in any of our intensive classes or programs other than therapies.

MANDATORY WAIVER: I give permission for photos of myself/my child to be used in promotional materials for Casa Care Pediatric Therapy, LLC during the screening event.

MANDATORY WAIVER: As a parent and/or legal guardian, I release and hold harmless Casa Care Pediatric Therapy, LLC it's owners and operators from any and in all liability, claims, demands, and causes of action whatsoever, arising out of or related to any loss , damage, or injury, that may be sustained by the participant and/or the undersigned, while in or upon the premises or any premises under the control and supervision of Casa Care Pediatric Therapy, LLC, its owners and operators or in route to or from any of said premises. I recognize that me or my child's attendance and participation may expose Me/him/her to risk of injury or harm. I accept this risk and agree that Casa Care Pediatric Therapy, LLC and its staff will not be held responsible should such injury or harm occur.

MANDATORY WAIVER: I have read and understand the complete Casa Care Pediatric Therapy, LLC policies presented above.

MISSED SCREENING SCHEDULED SESSION WAIVER: I understand that if I missed the scheduled screening session I may not be able to get a new appointment in within the same week.

NO DROP OFF POLICY: The main purpose of the screening session is to determine together with the family the need for either 1:1 intervention, intensive intervention or the need to participate in any of our programs. Therefore, we have a NO drop off policy for this appointment.

MEDICAL EMERGENCY: The undersigned gives permission to Casa Care Pediatric Therapy, LLC, its owners and operators to seek medical treatment for the participant in the event they are not able to reach a parent or guardian. I hereby declare any physical/mental problems, restrictions, or conditions and/or declare the participant to be in good physical and mental health. I request that our doctor/physician be called and that my child be transported to the hospital.

MEDICAL RELEASE FORM: If your child is recommended to participate from The Independence Program and he/she presents with a medical diagnosis a medical release form is required prior to starting in the program.

DISCLOSURE

If your child is recommended to receive any of our services early registration is highly encourage to assure space for your child. We reserve the right to cancel or re-schedule the screening appointment due to unforeseen events. If we have to cancel this appointment we will do our best to re-schedule the appointment in within a reasonable time frame.

FINAL ACKNOWLEDGEMENT

Parent(s) or Court-Appointed Legal Guardian(s) must sign for any participating minor (those under 18 years of age) and agree that they and the minor are subject to all the terms of this document, as set forth above. I certify that I am the Parent or Legal Guardian of the above minor.

Type name: _____

Signature: _____

Date: _____

Casa Care Pediatric Therapy, LLC
SCREENING RESULTS/RECOMMENDATIONS

www.casacarept.com/casacarept@yahoo.com/704.892.8074

TOOL USED:

INFANIB (BIRTH TO 18 MONTHS): SCORE: _____

FUNCTIONAL MOBILITY SCREEN:

SUPINE:

_____

_____

SITTING:

_____

_____

STANDING:

_____

_____

WALKING:

_____

_____

SUPPORT NEEDS:

_____

_____

MOVEMENT
CONCERNS:_____

_____

_____

COGNITION: MILD MODERATE SEVERE

CCPT ACHIEVEMENT PROGRAM: _____

SCREENING RECOMMENDATIONS:

_____

_____

_____

Referral to MD recommended (for direct PT/OT services): YES NO

_____

_____ _____

Signature of Therapist Completing Screen **Date**