BEACON
MEDICAL GROUP

Date

Dear Teacher:

The parents of one of your students are seeking to have their child evaluated by our office for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is greatly appreciated. Attached please find a Release of Information Form that the parents have completed and a set of teacher rating scales and questionnaires.

Generally, the teacher who spends the most time with the child should complete the teacher rating scales. However, if the child has more than one primary teacher, or has a special education teacher, it would be useful for us to obtain a separate set of rating scales from each teacher. If more than one set of rating scales is required, please have the parent contact the child's physician directly and we will forward additional rating scales as needed. Please note that the same teacher should complete each entire set of forms.

Please fill out the forms as completely as possible. If you do not know the answer to a question, please write, "Don't know", so that we can be sure the item was not simply overlooked. Some of the questions in the rating scales may seem redundant. This is necessary to ensure that we obtain accurate diagnostic information.

We ask that you complete these forms as soon as possible, as we are unable to begin a child's evaluation without the teacher rating scales. The forms should be mailed to us directly in the envelope provided.

Thank you for your assistance and cooperation in the completion of these forms.

Sincerely,

Beacon Medical Group Physicians

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 indicated 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 (toys, 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 when 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 other's (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
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 2 or 3 in questions 36-43:_____
Average Performance Score:_____

BEACON MEDICAL GROUP

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION			
Name	Telephone		Previous Name, If Different
Address	Birth Date		SS#
City	State	Zip	Date or Dates of Services

1. Facility authorized to release information:

   Office and Doctor Name: _____

   Address: _____

2. Person(s) or Facility authorized to receive the information:

   Teacher and School Name: _____

   School Address: _____

3. Description of information that may be used and disclosed:

❑ Entire Chart or as specified	❑ Laboratory Report(s)	❑ HIV, Aids, or AIDS related
❑ Face Sheet	❑ Immunization(s)	❑ Drug and/or Alcohol Abuse
❑ Discharge Summary	❑ Radiology Report(s)	❑ Mental Health
❑ History & Physical	❑ Operative Report(s)	☑ Other: Vanderbilt Teacher Assess. Form
❑ Consultant Report(s)	❑ Financial	

3a. **I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information.** _____ **Patient Must Initial**

4. The information will be used and disclosed for the following purposes:

❑ Transfer of Care	❑ Insurance	❑ Attorney/Legal	☑ Other: Evaluation

5. I understand that the Health information described above may be disclosed by the recipient and the information may no longer be protected by federal privacy regulations.

6. I understand that Beacon Medical Group may receive compensation for the use and disclosure of the information.

7. I understand that Beacon Medical Group will not condition my ability to obtain treatment on the provision of this Authorization.

8. I understand that I may revoke this Authorization in writing at any time by writing to Records Supervisor at Beacon Medical Group unless action has been taken in reliance upon this Authorization. This authorization expires 60 days from the date it is signed by me or unless specified otherwise. I understand there is a charge for copying medical records, $20 for single ($35 for family) for transfer of care. If this is for an attorney, personal use, or insurance, the charges will be per Indiana code I.C. 16-39-9. These charges do not apply for copies requested for continuing medical care with the Beacon Health System. By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Health Information in accordance with the terms of this Authorization.

Signature of Patient, Guardian or Legal Representative

Date Signed

Patient's Name (please print)

Printed Name of Personal Representative

Relationship to Patient

❑ Patient was given a copy of this Authorization

Witness

Released by

Authorization Expiration

Office use only:
DeliveryMethod:_____