Mobile Health Program

Le Bonheur's Mobile Health Program provides exceptional care beyond the hospital walls. We believe one way to serve children in West Tennessee is to provide well-child physicals, sports physicals and sick visits at their schools on a rotating basis. If your child already sees a provider, but your child visits the mobile unit, all information from the mobile health provider can be shared with your child's regular provider. It is our goal to connect children and families who do not have regular care to a pediatrician or primary care doctor in their community after their visit on our mobile medical unit. In addition, we can assist with referring children and families to specialty care as needed.

What you need to know:

- To be seen on the mobile medical unit, your child **must have a signed Le Bonheur consent form** on file. Participation in this program is voluntary.
- If your child gets sick while the mobile unit is at their school, the provider can see them if consent is on file.
- **Children are seen regardless of ability to pay.** Parents/caregivers should not be concerned about lack of insurance or costs of co-pays. We do bill TennCare insurances for patients who have it, but **parents should never receive a bill from us for services.**
- Parents/caregivers are welcome to come with their child on the mobile medical unit.
- Parents/caregivers will receive a visit summary with education material via mail and/or a phone call from Le Bonheur staff after the child's visit on the mobile unit.

Le Bonheur
Children's

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ DOB: _____

Health Questions

Child's Name: _____ Age: _____ Sex: M F Grade: _____

Is your child known by any other names? _____

School: _____ Phone Number for Parent/Guardian: _____

Child's Date of Birth: _____ Child's Social Security Number: _____

Address of Child: _____

Child's Race: ❑ Black ❑ White ❑ Asian ❑ Other_____ Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Preferred Language Spoken at Home: ❑ English ❑ Spanish ❑ Other _____

Child's Medical History (please mark any of the following medical conditions that apply to your child) ❑ **No Known Health Problems**

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

❑ Other Medical Conditions (please specify): _____

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. Include all prescription and nonprescription medication. ❑ **No Medications**
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? _____

_____

Does your child have an IEP? ❑ Yes ❑ No Does your child receive any therapies inside or outside of school? _____

Do you have any other medical concerns? _____

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

Child's Mother: ❑ No known Health Problems ❑ Deceased

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

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

Does the mother take cholesterol medication? ❑ Yes ❑ No

Child's Father: ❑ No known Health Problems ❑ Deceased

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

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

Does the mother 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: _____ (please specify)

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

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#:_____

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ DOB: _____

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:

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ **DOB:** _____

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 (□) _____ * + ● + □ =_____

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ **DOB:** _____

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. Pulmicort, Singulair, Flovent, etc.)	☐ Yes ☐ No
Is your child using the asthma controller medication? If not, why? (ex. Pulmicort, 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.)	☐ less than or = to 2 days/week ☐ greater than 2 days/week ☐ greater than 1 time/day
How often did the patient have **daytime** asthma symptoms for the past 4 weeks?	☐ less than or = to 2 days/week ☐ greater than 2 days/week ☐ daily ☐ greater than 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 ☐ greater than 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:

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ DOB: _____

Risk Assessment Information

Lead Screening	Yes	No
Have you ever been told your child has an elevated blood lead level?		
Does your child live in or regularly visit a house/school/child care facility built before 1978 that has recently been renovated?		
Does your child live in or regularly visit a house/school/child care facility built before 1950?		
Have you ever seen your child eating paint chips or other non-food substances such as paper?		

Tuberculosis Screening	Yes	No
Was your child born in a country that is at high risk for tuberculosis (other than the US)?		
Has your child traveled outside the USA? If so, Where?_____ When?_____		
Has your child been around someone who has been in jail or a shelter?		
Has your child been exposed to anyone with TB or a positive TB skin test?		
Is your child infected with HIV?		

Tobacco Use Screening	Yes	No
Is your child exposed to second-hand tobacco smoke?		

Dental Screening	Yes	No
Does the Parent/Guardian of child see a dentist regularly?		
Does the Parent/Guardian of child have dental decay or gum disease?		

Hunger/Anemia	Often	Sometimes	Never
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals and beans?			
Within the past 12 months, we worried whether our food would run out before we got money to buy more.			
Within the past 12 months, the food we bought just did not last and we did not have money to get more.			

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ **DOB:** _____

asthma.com

Patient's Name:_____

Today's Date: _____

Childhood Asthma Control Test for children 4 to 11 years

Know your score.

Parent or Guardian: The Childhood Asthma Control Test* is a way to help your child's healthcare provider determine if your child's asthma symptoms are well controlled. Take this test with your child (ages 4 to 11). Share the results with your child's healthcare provider.

Step 1: Have your child answer **the first four questions (1 to 4).** If your child needs help, you may help, but let your child choose the answer.

Step 2: Answer the last **three questions (5 to 7)** on your own. Don't let your child's answers influence yours. There are no right or wrong answers.

Step 3: Write the number of each answer in the score box to the right.

Step 4: Add up each score box for the total.

Step 5: Take the COMPLETED test to your child's healthcare provider to talk about your child's total score.

19 or less

IF YOUR CHILD'S SCORE IS 19 OR LESS, **Your child's asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your child's healthcare provider to talk about your child's results.**

NOTE: If your child's score is 12 or less, his or her asthma may be very poorly controlled. Please contact your child's healthcare provider right away.

Have your child complete these questions.

1. How is your asthma today?

0	1	2	3
Very bad	Bad	Good	Very good

2. How much of a problem is your asthma when you run, exercise or play sports?

0	1	2	3
It's a big problem, I can't do what I want to do.	It's a problem and I don't like it.	It's a little problem but it's okay.	It's not a problem.

3. Do you cough because of your asthma?

0	1	2	3
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.

4. Do you wake up during the night because of your asthma?

0	1	2	3
Yes, all of the time.	Yes, most of the time.	Yes, some of the time.	No, none of the time.

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

7. During the last 4 weeks, how many days did your child wake up during the night because of the asthma?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

SCORE

TOTAL

*The Childhood Asthma Control Test was developed by GSK.

This material was developed by GSK.

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Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ **DOB:** _____

asthma.com

Take this test if you are 12 years or older.

Share the score with your healthcare provider.

Name: _____ **Today's Date:** _____

ASTHMA CONTROL TEST™

Know your score.

The Asthma Control Test™ provides a numerical score to help you and your healthcare provider determine if your asthma symptoms are well controlled.

Step 1: Write the number of each answer in the score box provided.

Step 2: Add up each score box for the total.

Step 3: Take the completed test to your healthcare provider to talk about your score.

IF YOUR SCORE IS 19 OR LESS, **Your asthma symptoms may not be as well controlled as they could be. No matter what the score, bring this test to your healthcare provider to talk about the results.**

NOTE: If your score is 15 or less, your asthma may be very poorly controlled. Please contact your healthcare provider right away. There may be more you and your healthcare provider could do to help control your asthma symptoms.

					SCORE
1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?					
All of the time **[1]**	Most of the time **[2]**	Some of the time **[3]**	A little of the time **[4]**	None of the time **[5]**	.....
2. During the past 4 weeks, how often have you had shortness of breath?					
More than Once a day **[1]**	Once a day **[2]**	3 to 6 times a week **[3]**	Once or twice a week **[4]**	Not at all **[5]**	.....
3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?					
4 or more nights a week **[1]**	2 to 3 nights a week **[2]**	Once a week **[3]**	Once or twice **[4]**	Not at all **[5]**	.....
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?					
3 or more times per day **[1]**	1 to 2 times per day **[2]**	2 or 3 times per week **[3]**	Once a week or less **[4]**	Not at all **[5]**	.....
5. How would you rate your asthma control during the past 4 weeks?					
Not Controlled at All **[1]**	Poorly Controlled **[2]**	Somewhat Controlled **[3]**	Well Controlled **[4]**	Completely Controlled **[5]**	.....

TOTAL: .....

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Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

Patient Name: _____ DOB: _____

Le Bonheur On the Move: Mobile Medical Unit
Consent for Medical Examination and Care

Dear Parent/Guardian,

During the school year "Term" your child will have the opportunity to receive annual (or sports) physicals and medical care including sick visits provided by a Le Bonheur Children's Hospital "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 Medical Unit or designated site 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 understand the provider for Le Bonheur's Mobile Medical Unit may find a new illness, medical condition, or other needs for treatment. If this occurs, I understand someone from Le Bonheur's team will reach out to me to discuss findings and recommendations. I understand and agree this information may also be shared with my child's school as needed for ongoing treatment and care while at school. 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, Methodist Le Bonheur Community Outreach, 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.

Le Bonheur Children's

(Place Patient Identification Sticker Here)

Parent Name:_____

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, 1535 Vann Drive, 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 UT Le Bonheur Pediatric Specialists, Inc., Le Bonheur Children's Hospital, Methodist Le Bonheur Community Outreach, 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 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:
731-984-9954 (Direct Line)

_____

Signature of Parent/Guardian **Date**

PARENT/GUARDIAN INFORMATION

Name: _____ DOB:_____ SSN: _____
Last First MI

Parent/Guardian Email:_____

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

Alternate or emergency contact name?_____ Relation _____

Who else can we discuss your child's health with? _____

Who does your child live with? _____

Questions About Your Child's Health Care Provider

Has your child visited the doctor or healthcare 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 healthcare provider? _____ Phone: _____

Who is your preferred pharmacy?_____ Phone: _____