For Office Use Only
Chart #:
Account #:

APPLICATION

Weisskopf Child Evaluation Center-University of Louisville

571 S. Floyd Street, Suite 100, Louisville, KY 40202-3828 Telephone: (502) 588-0907 Fax: (502) 588-9534

Patient's Information

Today's Date: ___________ **Patient's Last Name:** ______________________________________ **First:** _______________________ **Middle:** _______

Birthdate: __________________ Sex: _____M _____F Patient's Social Security Number: ____

Race: *For statistical purposes only, please provide the child's race*. This information will be kept confidential.

☐ Caucasian ☐ African-American ☐ Asian/Pacific ☐ Native American ☐ Hispanic ☐ Bi-Racial ☐ Unknown ☐ Other ____________________

Primary Language Spoken: ____

Child's Residence: Street Address: ____

City: ____ State: _____________ Zip Code: ________________ County: __________________________

Home Phone: __________________________ Work Phone: _______________________________ Cell Phone: ____________________________

Other Phone: _________________________ Email Address: ____

Person Completing Application: ____ Relationship to Patient: ______________________________

Child lives with: ____ Relationship to Patient: ______________________________

Who will be responsible for the bill (guarantor)? ________________________________ Relationship to Patient: ___________________

Mother's Information

Mother's Name: Last: ____ First: ___________________________ Middle: _______________

Birth Date: ______________ Years of Schooling: __________ Occupation: ______________________________ Work Phone: ____________________

Father's Information

Father's Name: Last: ____ First: ___________________________ Middle: _______________

Birth Date: ______________ Years of Schooling: ____________ Occupation: ____________________________ Work Phone: ____________________

Parent / Legal Guardian Information

Parents are: *(Check One):* ☐ Natural/Biological ☐ Foster ☐ Adoptive ☐ Other: ____

Birth Name of Child: ____

Parent's Marital Status: *(Check One):* ☐ Married (Years) ☐ Single ☐ Separated ☐ Widowed ☐ Divorced

Who is the child's legal guardian? ____

Legal Guardian's Address (if different from child's):____

Telephone Number:____ Email Address:____

Emergency and Physician Information

Name of Emergency Contact: ____________________

Relationship: ____________________ Telephone: ____________________ Cell Phone: ____________________

My / My Child's Physician: ____________________ Street: ____________________

City ____________________ State: __________ Zip Code: ____________________ Telephone: ____________________

Referral Information

What have you been told about your condition (e.g., diagnoses and concerns) related to this referral to WCEC?____________________

____

What current services is your child receiving to address these concerns? ____________________

____

What is your goal for this evaluation? Why are you requesting this evaluation? ____________________

____

Birth and Pertinent Medical History

(Disregard if seen at WCEC previously)

Birth Hospital Name: ____________________ Street: ____________________

City: ____________________State: __________ Zip Code: __________ County: ____________________

Child was: ☐ Full term ☐ Premature ______________weeks Child's length of stay in the hospital? ______________ (Circle One: Days Weeks)

Additional information: ____________________

Birth and/or Perinatal complications, if any? ____________________

Current Medications

Medication	Dose	Medication	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Pertinent Medical History

Date	Findings/Condition/Accident	Medical Provider	Street Address, City, State, Zip Code

School Information

School Name: ______________________ Street: ______________________

City: ______________________ State: __________ Zip Code: __________ County: __________

Grade: ________ Does your child receive Special Education services? ☐ Yes ☐ No If yes, date of last evaluation: ______________

Evaluation findings: ______________________

____

Additional Services/Recent Care

☐ **Occupational Therapy** Agency Name: ______________________
Address: ______________________

☐ **Psychological Services/Therapy** Agency Name: ______________________
Address: ______________________

☐ **Speech/Language Therapy** Agency Name: ______________________
Address: ______________________

☐ **Vision** Agency Name: ______________________
Address: ______________________

☐ **Hearing** Agency Name: ______________________
Address: ______________________

☐ **Other** Agency Name: ______________________
Address: ______________________

Additional Information

Please include additional information that could be helpful to our physicians and clinicians:

____

____

____

____

____

BILLING AND INSURANCE INFORMATION

Primary Insurance

Insurance Name	Insurance Phone
Insurance Address	
Policy Holder's Name	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Insurance ID Number

Secondary Insurance

Insurance Name	Insurance Phone
Insurance Address	
Policy Holder's Name	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Insurance ID Number

The patient has *(Check one)*: **Passport** ☐ **Kentucky Medicaid** ☐

Patient's Name as it Appears on ID Card	Effective Date
Patient Passport/Medicaid ID Number	Patient Date of Birth
Primary Care Physician's Name	PCP's Telephone
PCP's Address	
Date patient last saw PCP	

Please provide our Center with copies of all medical insurance cards. Even if the patient has Passport or Medicaid, we must still have copies of any other medical insurance on the patient. Please verify with your insurance company if you need prior authorization for services. It is your responsibility to meet your insurance company's requirements for reimbursement.

I certify that the above information furnished by me is true and correct.

____ ________________________

Signature Date

GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

University of Louisville (UofL) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): ☐ Patient's Designee ☐ Provider Office

Name ______________________ Phone ______________________

Address ______________________

Street City State Zip

School Records Release Your Records To UofL

School Name ______________________ Phone ______________________

School Address ______________________

Street City State Zip

Patient Information, Signature, and Records Being Released:

______________________ ______________________

Patient's Name (Please Print) Date of Birth

×______________________ ×______________________

Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name ______________________

Records Being Released : Date Range From ______________ To ______________

☐ IEP/504 ☐ Samples of Current Work

Do Not Write Below This Line – For Office Use Only

UofL Practice Site (optional) ______________________

Phone ______________________ Fax ______________________

GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

University of Louisville (UofL) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): ☐ Patient's Designee ☐ Provider Office

Name ______________________________ Phone ______________________

Address ____

Street City State Zip

Birth Hospital Release Your Records To UofL

Hospital Name ______________________________ Phone ______________________

Hospital Address ____

Street City State Zip

Patient Information, Signature, and Records Being Released:

______________________________ ______________

Patient's Name (Please Print) Date of Birth

×______________________________ ×______________

Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name ______________________________

Records Being Released : Date Range From ____________ To ____________

☐ Entire Chart ☐ Labs ☐ Office Notes ☐ Other (Specify Below)

____

Do Not Write Below This Line – For Office Use Only

UofL Practice Site (optional) ______________________________________

Phone ____________________ Fax ____________________

GENERAL REQUEST FOR RELEASE OF MEDICAL RECORDS

To be used for release of information to the patient, whoever the patient designates release to, or to a provider of their choice; or to request the patient's records from another provider.

In order to release your/the patient's records, you must sign a request for release. This form must include the patient's name and date of birth. It is your responsibility to read this form in full and to ask any questions before the record is released. No phone call requests will be honored.

Designate Who You Want To Release Your Records:

University of Louisville (UofL) Release Your Records

The following information explains our policy for releasing protected health information:

- Medical records will be released only to the patient or to whoever the patient designates them to be released to.
- Law office/attorney medical records requests must have valid patient authorization with the request.
- Please be prepared to show ID when picking up records in person. This is for the protection of your personal health information.
- Patient's legal representatives must provide appropriate documentation to demonstrate their legal status.
- HIV, STD, substance abuse, and psychiatric records are not released without specific separate authorization.
- Please allow up to 30 days for records stored off site; however, UofL may take up to 60 days to process the request, if necessary.
- First copy provided free of charge.

Release Records to (provide information below): ☐ Patient's Designee ☐ Provider Office

Name ______________________________ Phone ____________________

Address ____

Street City State Zip

Primary Care Doctor Release Your Records To UofL

Provider Name ______________________________ Phone ____________________

Provider Address ____

Street City State Zip

Patient Information, Signature, and Records Being Released:

______________________________ ____________________

Patient's Name (Please Print) Date of Birth

×______________________________ ×____________________

Patient/Parent/Legal Guardian Signature Date

If Parent/Legal Guardian, Print Name ______________________________

Records Being Released : Date Range From ______________ To ______________

☐ Problem List ☐ Growth Chart ☐ Diagnostic Testing ☐ Labs ☐ Consult Notes

Do Not Write Below This Line – For Office Use Only

UofL Practice Site (optional) ____

Phone ____________________ Fax ____________________