Happy Hungry Hippos

Information Packet

4650 Glenforest Drive • Roswell, Georgia 30075 • tel 404.933.9869 • fax 703.997.4038 • charlene@happyhungryhippos.com • www.happyhungryhippos.com

Dear Parent,

Having a child who does not feed well is a worrisome, frustrating, confusing and at times, medically concerning problem. We, at Happy Hungry Hippos LLC., understand how complex feeding difficulties can be. Because of these complexities, we believe it is important to look at the "whole" child and to assess all the possible contributing factors in a feeding problem. The Occupational Therapist is committed to helping you and your child identify what is interfering with your child's eating and how to improve their growth and interactions with food.

In order to best help us prepare for your child's evaluation, we would like you to carefully read over the following information and to complete the enclosed forms; **Case History Form, Feeding History Form, 3 Day Diet History, Release of Information, Patient Rights Form and Notice of Privacy Practice. P**lease complete the forms in as much detail and as readable as possible. Many items on the forms can be simply answered by checking YES or NO in the appropriate space. If you give a YES response, please explain this answer thoroughly in the space provided or on the back of the page. If you can not, or wish to not answer a question, leave it blank. If a question does not apply to your child, you may write in NA for "not applicable".

Please return your completed forms by mailing them AT LEAST 1 WEEK in advance of your scheduled appointment date. If you are not able to mail them before the one week deadline, please just bring the forms with you to the appointment so that they are not caught up in our mail system. IF YOU ARE BRINGING YOUR FORMS WITH YOU TO YOUR APPOINTMENT, YOU NEED TO ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME for the therapist to review the paperwork.

Our mailing address is:
Happy Hungry Hippos, LLC
4650 Glenforest Dr. NE
Roswell, GA 30075

Your Child's appointment is scheduled for: _____

THE FEEDING APPOINTMENT:

On the day of your appointment, the Occupational Therapist will be observing you and your child having a snack together.

For the appointment, we would like you t**o bring at least 2 foods of different textures and 1 drink that your child will most likely eat, and at least 1 food your child will most likely refuse.** We want to be able to evaluate your child's current skill level, as well as determining how they handle more challenging foods.

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Please also **pack your child's preferred utensils, cup, bottles and dishes** to make the assessment situation as "home-like" as possible. We find it helpful to explain to older children that you are packing a "picnic" to eat together at the therapist's office, and that the therapists' job is to help children and families learn to eat better together. We would also ask that you give your child only a light breakfast on the day of their appointment and that you **NOT feed them for at least 1 ½ hours before** their scheduled appointment time.

REQUEST FOR MEDICAL RECORDS:

Enclosed you will find a form for requesting medical records and giving us permission to communicate with other professionals also treating your child. Please make as many copies of this form as needed, and submit one to each of the other professionals caring for your child. At a minimum, please complete the form and submit it to your child's primary care physician. If your doctor or any other therapist would like to speak to the therapist prior to the appointment, please have them call Charlene Kurkjian, OTR/L at (404) 933-9869. We gladly welcome any and all forms of communication with the other professionals treating your child, so as to be most helpful to everyone involved.

If you have any questions about this information or the forms you are to complete, please feel free to call Charlene Kurkjian, OTR/L at (404) 933-9869.

CASE HISTORY FORM

GENERAL INFORMATION

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

Child's Preferred Name (if different): _____ DOB: _____ Age _____

Home Address: _____
street

_____
city/state/zip

Home Phone: (_____)_____

General Diagnosis: _____

FAMILY INFORMATION

Mothers Name: _____

Primary Phone #: (_____)_____ Email _____

Fathers Name: _____

Primary Phone #: (_____)_____ Email _____

List all people living in household

Name _____ Relationship to Child _____ Age _____

Name _____ Relationship to Child _____ Age _____

Name _____ Relationship to Child _____ Age _____

Name _____ Relationship to Child _____ Age _____

If adopted, at what age: _____ School Child Attends: _____

Child's primary language: _____ Primary language spoken in the home? _____

REFERRAL INFORMATION

Referred by: _____

Phone: (_____) _____ Address: _____

Primary Care MD: _____

Phone: (_____) _____ Address: _____

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PEDIATRIC FEEDING HISTORY FORM

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

1. Please explain, is your own words, what your child's current feeding problem is:

   _____

   _____

   _____

   _____

2. Was your child breast fed? _____ From when to when _____

   _____

   Was your child bottle fed? _____ From when to when _____

   _____

   _____

   Please describe your child's initial skill on the breast and/or bottle: _____

   _____

   _____

3. During these early feedings, did your child frequently arch, cry, spit up, gag, cough, vomit or pull off the nipple?

   _____

   Circle the behaviors shown and describe when they would happen, why, for how long:

   _____

   _____

4. Describe how the weaning process off the breast and/or bottle went and why the child was weaned: _____

   _____

   _____

   _____

5. At what age did your child transition to:

   Baby cereal? _____ Baby food? _____ Finger foods? _____ Transition fully to table food? _____

   Please describe how these transitions were handled by your child, especially if any difficulties happened:

   _____

   _____

   _____

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6. IF YOUR CHILD EATS BY MOUTH, PLEASE ANSWER THE FOLLOWING QUESTIONS:

6a. List the foods that your child currently will eat and drink (put a star next to their favorites): _____

_____

_____

6b. List the foods your child refuses: _____

_____

_____

6c. List the foods your child is allergic to: _____

_____

_____

6d. Describe your child's mealtime:

Who typically feeds your child? _____

Who typically eats with your child? _____

What type of chair is used? _____

How long are meals typically?_____

Does your child use utensils or any type of special cups/bowls (describe)? _____

_____

Are there any other activities going on at meals? What activities (describe)? _____

_____

6e. What times does your child typically eat and what type (bottle, breast, solids)?_____

_____

7. IF YOUR CHILD IS TUBE FED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

7a. What type of formula is used and how do you mix it? _____

_____

7b. Please detail your child's feeding schedule below.

Time of feeding (start time)	NG, G or Continuous	Amount	Gravity or Pump	Over what time period (or what rate)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

7c. Describe where your child is tube fed and what activities are occurring at the same time: _____

_____

_____

7d. Describe your child's reactions to the tube feedings (connecting, during, disconnecting): _____

_____

_____

*PLEASE ANSWER FOR ALL CHILDREN

8. Has your child ever been on any type of special diet other than what you just described? _____

   If yes, please describe type of diet, at what ages, why and what was your child's response: _____

_____

_____

9. How do you know your child is hungry or full? _____

_____

_____

10. Has your child lost or gained any weight in the last 6 months, and how much? _____

_____

11. Would you describe your child's weight as (circle one): Ideal Underweight Overweight

12. Does your child have/had any of the following problems? Please describe:

    Dental, frequent constipation, frequent diarrhea, vomiting, choking, gagging, coughing

_____

_____

13. Does your child take a vitamin supplement? Which one? _____

_____

_____

14. Describe how you, and your child feel after a feeding:

    You: _____

    Your child: _____

15. What other evaluations have been completed regarding your child's feeding difficulties and what were the results/what were you told? _____

_____

_____

16. What treatments have been tried for this problem, and what were the results? _____

_____

_____

_____

_____

_____

17. How can we be most helpful to you and your child? _____

_____

_____

_____

_____

_____

3 DAY DIET HISTORY FORM

INSTRUCTIONS

You are being asked to record all foods and drinks eaten/ drank by your child for 3 days in a row. The following directions will guide you in filling out the form. You need to complete this history and send the information to the Feeding Center with the rest of your forms, OR you will need to bring it with you to your appointment.

1. Please fill out ALL the information at the top of the first page.

2. Please record the DATE and DAY of the week for each day. Record ALL food and drinks eaten along with the TIME your child ate or drank them. It is best to carry the history form with you and to record items immediately so that nothing is missed.

3. Include an EXACT description of the item and your best guess of the portion size of the amount eaten. Write the brand name of formula your child is on (i.e. Enfamil, Prosobee, etc.), what type of juice he/ she drank (i.e. apple, grape, etc.), any special recipes for drink mixtures your child uses (i.e. 24 calorie Isomil + 1 tsp Polycose), and any additions to foods (i.e. ¼ cup mashed potatoes + 1 Tbsp margarine). Be sure to include dressings, sauces, gravies, or anything extra.

4. It is suggested that you may wish to use measuring spoons and cups when serving your child for these 3 days to report the amounts eaten/ drank better.

EXAMPLE

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube
1/1/02	4 pm	Gerber applesauce #2	1 ounce			a	
		White Bread	¼ slice			a	
		Ham lunch meat	½ ounce			a	
		Mayonnaise	1 tsp			a	
		White grape juice	1 ounce		a	a	
	7 pm	Similac Formula	4 ounces	a		a	
	9 pm	Pediasure with fiber	8 ounces				a

TURN OVER FOR USABLE FORMS

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OFFICE USE ONLY

Ht:_____ Wt:_____ Date:_____

Estimated Needs: _____ Calories
_____ Protein
_____ Fluid

_____ Eval_____ Individual _____ Group

Parent/ Guardian Name: _____ Daytime Phone #:_____

Child's Name: _____ Date of Birth:_____

Vitamin or Mineral Supplement: ❑ NO ❑ YES Name & Amount: _____

Formula Mixing: Number of scoops:_____
Amount of Water: _____

_____ I put water in the bottle first then the formula powder.
_____ I put the formula powder in the bottle first then the water.
_____ The formula is liquid in a can and I do not add anything.

Date	Time	Food/ Drink Item	Amount	Bottle	Cup	Mouth	G-tube

PERMISSION TO SHARE AND RELEASE INFORMATION
Duo Release Form

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I hereby authorize Happy Hungry Hippos, LLC to share information regarding the evaluation and treatment of my child (named patient above) for the purposes of treatment planning and coordination. I authorize the release of such information as the treating therapist deems relevant and pertinent to the professional listed below.

I also authorize Happy Hungry Hippos, LLC to obtain information about my child's treatment from the provider listed below. I authorize the provider to release complete information from the medical, school, social service and/or psychological record of my child (named patient above).

NAME OF PROVIDER: _____

ADDRESS: _____

_____

_____

PHONE NUMBER: _____

Signature of Parent/Legal Guardian _____ Date _____

Signature of Witness _____Date _____

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Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to makes changes in our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice Available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for your treatment, payment, and health care operations.
For example:

Treatment: We may use and disclose your health information to a physician or other health care provider proving treatment to you.

Payment: We may use and disclose your health information to obtain payment services we provide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualification of health care professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, and credential activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those describes in this Notice.

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To your family and friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family, member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses and disclosers. In the event of your incapability or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use of disclose your health information what we are required to do so by law.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may not disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail message messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other cost incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, health care operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternate locations. (You must make your request in writing.) Your requests must specify the alternative means or location, and provide satisfactory explanation will be handled under the alternative means location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complains to us and to Secretary of the Department of Health and Human Services if you believe that your privacy right have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Leader. Right to Obtain a Paper Copy of this Privacy Summary Notice as well as the Full Privacy Notice.

Questions and Complaints

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to privacy of your health information. You will not be penalized in any way if you choose to file a complaint with us and / or with the U.S. Department of Health and Human Services.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)