Child Study Center & Center on Child Abuse & Neglect
1100 NE 13th St. Oklahoma City, OK 73117-1039
Phone: 405-271-5700 Fax: 405-271-2992

DUE TO EXISTING LONG WAITING LISTS, MANY OF OUR SERVICES ARE CURRENTLY UNABLE TO ACCEPT NEW APPOINTMENT REQUESTS OR REFERRALS. PLEASE DO NOT SUBMIT REQUESTS FOR THE SERVICES LISTED BELOW:

Page 10 of the APPOINTMENT REQUEST / SELF REFERRAL FORMS has descriptions of the types of services currently available at Child Study Center.

NOT ACCEPTING NEW PATIENTS	**ADHD AND DEVELOPMENTAL-BEHAVIORAL PEDIATRIC CLINIC** Medical evaluations and treatment as needed including medication management for patients, age birth to 18 years, with complex neurodevelopmental disorders including ADHD and other disruptive behavior disorders, autism spectrum disorders, language disorders, and intellectual disability, among others.

NOT ACCEPTING NEW PATIENTS	**BEHAVIOR CLINIC AND PARENT CHILD INTERACTION THERAPY (PCIT)** Assessment and treatment services for children and adolescents with a wide variety of emotional and behavioral problems.

NOT ACCEPTING NEW PATIENTS	**JUMPSTART / AUTISM EVALUATION CLINIC** Evaluations for children age 6 years 11 months old and younger with suspected autism spectrum disorders.

NOT ACCEPTING NEW PATIENTS	**PEDIATRIC NEUROPSYCHOLOGY CLINIC** Comprehensive neuropsychological evaluations for patients age 2 to 18 with medical, neurological, and/or neurodevelopmental disorders.

NOT ACCEPTING NEW PATIENTS	**SPECIALIZED ASSESSMENT CLINIC** Psychological evaluations for children ages 5 and older for a variety of problems such as Autism, ADHD, Emotional/Behavioral disturbances, and learning disabilities. Clinic also provides outpatient Cognitive Behavior Therapy services. This is NOT a medical evaluation.

For other resources, we highly recommend you contact Sooner Success. It is a program offered through the OU Child Study Center that helps families raising a child with special needs find resources in their community. Their website and county coordinators can help families navigate community resources in general. Their website has a detailed list of several other mental healthcare providers in the community that may be able to help meet your family's needs. The list also includes providers outside the metro area that fit a wide range of pediatric healthcare needs. We hope this information will be helpful to your family in finding resources for their child and connecting them to other helpful services. To view the full list of resources, call toll free 1-877-441-0434 or visit http://soonersuccess.ouhsc.edu/Resources/ChildStudyCenterResourcesList.aspx

Child Study Center
Appointment Request / Self Referral Instructions

The following 10 page "CHILD STUDY CENTER APPOINTMENT REQUEST / SELF REFERRAL FORMS" are required to request an appointment at the Child Study Center. Please include copies of both sides of insurance cards with all requests for appointments. If applicable and available, please copy (on one side only, no front and back copies, please) and attach any records of previous evaluations, hearing tests, and school forms like "IEP"s or "504 Plans." You may use a separate sheet of paper to write more than space allows on the referral forms. **Your child's name and date of birth are required on each page being submitted. Remove all staples and paperclips. Please do not submit double sided copies; documents should have print on only one side of each page.**

If the child's insurance requires a referral such as Soonercare, the Primary Care Physician *is required* to submit a physician referral.

If the child is in **DHS Custody or Foster Care**, the DHS caseworker *is required* to submit signed consent forms. Please contact us to receive these forms for completion.

Please Mail or Fax all documents to:

Child Study Center
New Appointments and Referrals
1100 NE 13th Street
Oklahoma City OK 73117
Phone: 405-271-5700
Fax: 405-271-2992

When all required documents are received, the request will be processed and the family will be contacted. Please be aware there could be a substantial wait before you hear from us and an appointment may be scheduled. At this time, **some of our clinics are unable to accept new appointment requests.** Please check page 10 of the appointment request forms to make sure we are able to provide the type of services you are needing and only submit requests for available services.

For more resources, call toll free 1-877-441-0434 or visit
http://soonersuccess.ouhsc.edu/Resources/ChildStudyCenterResourcesList.aspx

OU Children's Physicians
CHILD STUDY CENTER

CHILD STUDY CENTER

APPOINTMENT REQUEST / SELF REFERRAL FORMS

PATIENT NAME: (FIRST MIDDLE LAST) **GENDER**: ☐M ☐F

DATE OF BIRTH: **AGE:** **SOCIAL SECURITY #:**

MAILING ADDRESS:

CITY: **STATE:** **ZIP:** **COUNTY:**

PREFERRED PHONE # : **PLEASE INDICATE TYPE: CELL HOME OTHER**

ALTERNATE PHONE #: **PLEASE INDICATE TYPE: CELL HOME OTHER**

PARENT/CAREGIVER NAME(S):

PARENT/CAREGIVER TYPE (CHECK ALL THAT APPLY): ☐BIOLOGICAL PARENT ☐GRANDPARENT ☐ADOPTIVE PARENT
☐STEP PARENT ☐LEGAL GUARDIAN ☐FOSTER PARENT** ☐OTHER:

PARENT/CAREGIVER EMAIL:

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT OF SERVICES)

NAME: DATE OF BIRTH:

SOCIAL SECURITY #: RELATIONSHIP TO PATIENT:

MAILING ADDRESS: (City State Zip)

PHONE # PREFERRED: ALTERNATE PHONE #:

EMAIL: EMPLOYER:

PATIENT'S ETHNICITY: ☐NON-HISPANIC ☐HISPANIC ☐UNKNOWN ☐REFUSED

PATIENT'S RACE: (CHECK ALL THAT APPLY) ☐AFRICAN AMERICAN/BLACK ☐AMERICAN INDIAN OR ALASKAN ☐ASIAN ☐WHITE
☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND ☐OTHER (SPECIFY):

PATIENT'S LANGUAGE PREFERENCE: **TRANSLATOR NEEDED?** ☐YES ☐NO

IF CANCELLATION RESULTING IN AVAILABLE APPOINTMENT OCCURRED, COULD YOU COME ON SHORT NOTICE?

☐NO ☐YES IF YES, HOW MUCH NOTICE DO YOU NEED? ☐1 HOUR ☐4 HOURS ☐OTHER

WHAT PHONE NUMBER SHOULD WE CALL TO CONTACT YOU IN THIS SITUATION?

****IS PATIENT IN DHS CUSTODY? ☐NO *☐YES If YES, provide Caseworker information**

DHS CASEWORKER NAME: CASEWORKER FAX #:

CASEWORKER CELL PHONE #: CASEWORKER OFFICE PHONE #:

CASEWORKER EMAIL: CASEWORKER COUNTY:

INSURANCE INFORMATION - PROVIDE COPIES OF BOTH SIDES OF INSURANCE CARD(S)

NAME OF PRIMARY INSURANCE COMPANY:

POLICY HOLDER NAME: POLICY ID#:

POLICY HOLDER DATE OF BIRTH: POLICY GROUP / PLAN #:

POLICY HOLDER RELATIONSHIP TO PATIENT: POLICY HOLDER EMPLOYER:

NAME OF SECONDARY INSURANCE COMPANY:

POLICY HOLDER NAME: POLICY ID#:

POLICY HOLDER DATE OF BIRTH: POLICY GROUP / PLAN #:

POLICY HOLDER RELATIONSHIP TO PATIENT: POLICY HOLDER EMPLOYER:

PATIENT'S REGULAR DOCTOR (PRIMARY CARE PHYSICIAN - PCP)?

PCP NAME: FACILITY:

PCP ADDRESS: (City State Zip)

PCP PHONE #: FAX#:

PRINTED NAME OF PERSON COMPLETING THESE FORMS:

RELATIONSHIP TO PATIENT: **DATE FORMS COMPLETED:**

CHILD STUDY CENTER

APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

CONCERNS:

Please tell us, in your own words, what your main concerns are for this child and why you are seeking this appointment. (For example: Medication consult, ADHD evaluation and treatment, counseling, problem behaviors, anxiety, abuse, trauma, learning impairments, dyslexia, speech delays, etc.) If learning problems, please specify the social and emotional impact of impairments. If Autism, please sepcify symptoms (nightmares, not getting along with others, physically aggressive, developmental delay, etc.) Please use a separate sheet if you need to write more than space allows. Please attach copies of any records of previous evaluations, hearing tests, school forms like IEP's or 504 plans.

CHECK ALL SYMPTOMS OR BEHAVIORS THAT APPLY TO THIS CHILD:

- ☐ AGGRESSIVE
- ☐ ANGRY
- ☐ ANXIOUS/SCARED
- ☐ ARGUES
- ☐ CHRONIC ILLNESS
- ☐ CLINGY
- ☐ CONSTIPATION
- ☐ CRIES OFTEN/VERY UPSETTABLE
- ☐ DEPRESSED
- ☐ DOESN'T FOLLOW DIRECTIONS
- ☐ DOESN'T PAY ATTENTION
- ☐ DOESN'T PLAY WELL WITH OTHER CHILDREN
- ☐ DOESN'T SEEM TO UNDERSTAND
- ☐ EXTREME TANTRUMS
- ☐ FLAPS HANDS
- ☐ GROWTH CONCRENS
- ☐ HEARING LOSS
- ☐ HIGH PAIN TOLERANCE
- ☐ HYPERACTIVE
- ☐ KICKED OUT OF DAY CARE/SCHOOL
- ☐ LEARNING DIFFICULTIES
- ☐ LINES THINGS UP
- ☐ LYING
- ☐ NOT TALKING WELL
- ☐ PICKY EATER
- ☐ SENSITIVE TO SOUNDS
- ☐ SENSITIVE TO TEXTURES
- ☐ SPINS THINGS OR SELF
- ☐ TOILETING CONCERNS
- ☐ OTHER - DESCRIBE BELOW

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APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

MEDICAL HISTORY

HOW WOULD YOU DESCRIBE THIS CHILD'S OVERALL HEALTH?

☐ POOR ☐ FAIR ☐ GOOD ☐ VERY GOOD ☐ EXCELLENT

HAS THIS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? CHECK ALL THAT APPLY

☐ EYES CROSSING/LAZY EYE	☐ FAINTING	☐ SEASONAL ALLERGIES
☐ WEARS GLASSES	☐ CAVITIES	☐ HEARING PROBLEMS
☐ OVERNIGHT HOSPITAL STAY	☐ EAR TUBES	☐ CONSTIPATION
☐ HEART PROBLEMS	☐ ASTHMA	☐ MAJOR SURGERY
☐ OTHER - DESCRIBE		

CHILD						BLOOD RELATIVE	
DIAGNOSED		EVALUATED		TREATED	**INDICATE IF THIS CHILD OR A BLOOD RELATIVE OF THIS CHILD HAS EVER BEEN DIAGNOSED, EVALUATED, OR TREATED FOR ANY OF THE FOLLOWING**	DIAGNOSED	WHICH BLOOD RELATIVE?
☐		☐		☐	AUTISM SPECTRUM DISORDER	☐	
☐		☐		☐	ASPERGERS DISORDER	☐	
☐		☐		☐	PERVASIVE DEVELOPMENTAL DISORDER (PDD)	☐	
☐		☐		☐	DEVELOPMENTAL DELAY	☐	
☐		☐		☐	INTELLECTUAL DISABILITY (FORMERLY MENTAL RETARDATION)	☐	
☐		☐		☐	EMOTIONALLY DISTURBED (A SCHOOL DIAGNOSIS)	☐	
☐		☐		☐	ATTENTION DEFECIT HYPERACTIVITY DISORDER (ADHD)	☐	
☐		☐		☐	OPPOSITIONAL DEFIANT DISORDER (ODD)	☐	
☐		☐		☐	ANXIETY DISORDER/PANIC ATTACKS	☐	
☐		☐		☐	BIPOLAR DEPRESSION	☐	
☐		☐		☐	DEPRESSION	☐	
☐		☐		☐	SCHIZOPHRENIA	☐	
☐		☐		☐	ATTACHMENT DISORDER	☐	
☐		☐		☐	POST TRAUMATIC STRESS DISORDER (PTSD)	☐	
☐		☐		☐	OBSESSIVE-COMPULSIVE DISORDER (OCD)	☐	
☐		☐		☐	SEPARATION ANXIETY DISORDER	☐	
☐		☐		☐	GENETIC DISORDER	☐	
☐		☐		☐	SEIZURE DISORDER	☐	
☐		☐		☐	HEART DISEASE/SUDDEN DEATH AT YOUNG AGE	☐	
☐		☐		☐	LEARNING DISABILITY	☐	
☐		☐		☐	SPECIAL EDUCATION	☐	
☐	OTHER - DESCRIBE						

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APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

LIST ALL MEDICATIONS, HERBS, TREATMENTS, OR SPECIAL DIETS THIS CHILD TAKES OR USES

USE A SEPARATE SHEET IF YOU NEED MORE SPACE

MEDICATIONS/HERBS/TREATMENTS/SPECIAL DIETS	DOSAGE	FREQUENCY	REASON

ALLERGIES

IS THIS CHILD ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, NAME OF MEDICATION	DATE OF MOST RECENT REACTION	SYMPTOMS EXPERIENCED

IS THIS CHILD ALLERGIC TO ANY FOODS? ☐ YES ☐ NO

IF YES, NAME OF FOOD	DATE OF MOST RECENT REACTION	SYMPTOMS EXPERIENCED

IS THIS CHILD ALLERGIC TO ANYTHING ELSE? ☐ YES ☐ NO

IF YES, WHAT	DATE OF MOST RECENT REACTION	SYMPTOMS EXPERIENCED

DATE OF MOST RECENT HEARING TEST _____ LOCATION _____ RESULTS _____

DATE OF MOST RECENT VISION TEST _____ LOCATION _____ RESULTS _____

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APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

DEVELOPMENTAL HISTORY

INDICATE WHAT YOU FEEL IS THIS CHILD'S DEVELOPMENT IN THE FOLLOWING AREAS

ADVANCED	AVERAGE	BEHIND	VERY BEHIND	
☐	☐	☐	☐	PHYSICAL DEVELOPMENT
☐	☐	☐	☐	MOTOR SKILL DEVELOPMENT
☐	☐	☐	☐	EMOTIONAL DEVELOPMENT
☐	☐	☐	☐	ACADEMIC DEVELOPMENT
☐	☐	☐	☐	LANGUAGE DEVELOPMENT
☐	☐	☐	☐	INTELLECTUAL AND THINKING SKILLS DEVELOPMENT
☐	☐	☐	☐	SOCIAL DEVELOPMENT
☐	☐	☐	☐	PROBLEM SOLVING SKILLS
☐	☐	☐	☐	FINE MOTOR SKILLS
☐	☐	☐	☐	DAILY LIVING SKILLS (LIKE GETTING DRESSED OR TOILETING)
☐	☐	☐	☐	RELATIONSHIP WITH SILBINGS
☐	☐	☐	☐	RELATIONSHIP WITH PARENTS AND CAREGIVERS

AT WHAT AGE (IN MONTHS) DID THIS CHILD:

CRAWL _____ TAKE FIRST STEP _____ WALK _____ RUN _____

AT WHAT AGE (IN MONTHS) DID THIS CHILD SPEAK:

FIRST WORD _____ 2 WORD PHRASES _____ FULL SENCENCES _____

HOW DOES THIS CHILD COMMUNICATE - CHECK ALL THAT APPLY

☐ GESTURES ☐ WORDS ☐ PHRASES ☐ SENTENCES

☐ OTHER: _____

WHAT DOES THIS CHILD DO WITH A PENCIL - CHECK ALL THAT APPLY

☐ SCRIBBLE
☐ COPY A CIRCLE
☐ COPY A SQUARE
☐ COPY A TRIANGLE
☐ DRAW A LINE
☐ DRAW A SIMPLE PERSON
☐ DRAW A PERSON WITH MANY BODY PARTS
☐ DRAW RECOGNIZABLE THINGS
☐ OTHER: _____

CHILD STUDY CENTER

APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

EDUCATION

AGE AT WHICH YOU OR OTHERS BECAME CONCERNED ABOUT THIS CHILD'S DEVELOPMENT _____

DOES THIS CHILD ATTEND SCHOOL ☐ YES ☐ NO

WHAT GRADES DOES THIS CHILD MAKE ☐ A'S ☐ B'S ☐ C'S ☐ D'S ☐ F'S

HAS THIS CHILD EVER REPEATED A GRADE ☐ YES ☐ NO

NAME OF CURRENT SCHOOL _____ GRADE _____

TEACHER'S NAME _____ CITY _____

DO YOU HAVE ANY CONCERNS REGARDING THIS CHILD'S EDUCATIONAL PERFORMANCE

☐ NO ☐ YES - DESCRIBE _____

INDICATE ANY SERVICES PAST OR PRESENT RELATED TO THIS CHILD

PROVIDE ANY RECORDS AVAILABLE OF THESE EVALUATIONS, SERVICE PLANS, AND DIAGNOSTIC TESTING

CURRENT	PAST	ON WAITING LIST	INTERESTED		DATE SERVICE BEGAN	DATE SERVICE ENDED
☐	☐	☐	☐	EARLY INTERVENTION / SOONER START		
☐	☐	☐	☐	DEVELOPMENTAL DELAY PRESCHOOL		
☐	☐	☐	☐	HEAD START		
☐	☐	☐	☐	INDIVIDUALIZED EDUCATION PLAN (IEP)		
☐	☐	☐	☐	PRE-K		
☐	☐	☐	☐	SPEECH THERAPY		
☐	☐	☐	☐	OCCUPATIONAL THERAPY		
☐	☐	☐	☐	PHYSICAL THERAPY		
☐	☐	☐	☐	SOCIAL SKILLS GROUP		
☐	☐	☐	☐	COUNSELING		
☐	☐	☐	☐	PARENTING CLASS		
☐	☐	☐	☐	BEHAVIOR THERAPY		
☐	☐	☐	☐	OTHER		

More Information: _____

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Patient Name _____ Patient Date of Birth _____

HOME AND FAMILY

LIST EVERYONE WHO LIVES WITH THIS CHILD

FULL TIME	PART TIME	NAME OF INDIVIDUAL	RELATIONSHIP TO CHILD

HAS THIS CHILD LIVED IN OTHER HOMES PRIOR TO THE CURRENT HOME ☐ YES ☐ NO

WHO PROVIDES SUPPORT TO THE PRIMARY CAREGIVER IN CARING FOR THIS CHILD - CHECK ALL THAT APPLY

- ☐ CHILD'S IMMEDIATE FAMILY
- ☐ CHILD SUPPORT PAYMENTS
- ☐ SOCIAL SECURITY
- ☐ WELFARE
- ☐ SOONERCARE / MEDICAID
- ☐ WIC / FOOD STAMPS / EBT
- ☐ UNEMPLOYMENT PAYMENTS
- ☐ FRIENDS
- ☐ SUPPORT GROUP
- ☐ TRIBAL SUPPORT / TRIBAL AFFILIATION
- ☐ MORE SUPPORT IS NEEDED
- ☐ CAREGIVER'S IMMEDIATE FAMILY LIKE GRANDPARENTS
- ☐ HOUSING ASSISTANCE ☐
- ☐ DISABILITY
- ☐ TANF
- ☐ PRIVATE INSURANCE
- ☐ FREE/REDUCED SCHOOL MEALS
- ☐ PARENT/FAMILY NETWORKS
- ☐ CHURCH
- ☐ DAYCARE
- ☐ ENERGY ASSISTANCE
- ☐ OTHER DESCRIBE BELOW

More Information:

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Patient Name _____ Patient Date of Birth _____

CHILD TRAUMA HISTORY

HAS THE CHILD EXPERIENCED A TRAUMATIC EVENT? ☐ NO ☐ SUSPECTED

☐ YES, CONFIRMED IF "YES" PLEASE CHECK ALL THAT APPLY

- ☐ PHYSICAL ABUSE
- ☐ SEXUAL ABUSE
- ☐ NEGLECT
- ☐ PSYCHOLOGICAL / EMOTIONAL ABUSE
- ☐ WEATHER DISASTER
- ☐ WITNESSED INTIMATE PARTNER VIOLENCE (IPV) / DOMESTIC VIOLENCE (DV)
- ☐ OTHER - DESCRIBE BELOW
- ☐ ACCIDENT
- ☐ COMMUNITY VIOLENCE
- ☐ MEDICAL PROCEDURE / ILLNESS
- ☐ SCHOOL VIOLENCE
- ☐ WAR / TERRORISM

More Information:

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APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name _____ Patient Date of Birth _____

PREGNANCY AND BIRTH HISTORY

WAS THIS CHILD'S PREGNANCY EXPECTED? ☐ YES ☐ NO

MOTHER'S AGE AT PREGNANCY _____

WERE THERE FERTILITY PROBLEMS? ☐ YES ☐ NO

NUMBER OF PRIOR PREGNANCIES _____

NUMBER OF PRIOR MISCARRIAGES _____

NUMBER OF WEEKS PREGNANT WHEN PREGNANCY WAS DISCOVERED _____

DID THIS CHILD'S MOTHER USE ALCOHOL, TOBACCO, OR DRUGS DURING PREGNANCY, INCLUDING BEFORE THE PREGNANCY WAS KNOWN? IF YES, PLEASE CHECK ALL THAT APPLY

☐ ALCOHOL ☐ TOBACCO ☐ RECREATIONAL DRUGS ☐ PRESCRIPTION MEDICAIONS

LIST ALL RECREATIONAL AND PRESCRIPTION DRUGS TAKEN DURING PREGNANCY:

_____

_____

COMPLICATIONS DURING PREGNANCY ☐ YES ☐ NO IF YES, DESCRIBE _____

_____

DID THIS CHILD'S MOTHER NEED TO VISIT THE EMERGENCY ROOM DURING PREGNANCY ☐ YES ☐ NO

IF YES, DESCRIBE _____

NUMBER OF WEEKS AT DELIVERY _____ BIRTH WEIGHT: POUNDS _____ OUNCES _____

COMPLICATIONS OF DELIVERY ☐ LONG LABOR ☐ INFECTION ☐ NICU

☐ TROUBLE BREATHING/RESPIRATORY DISTRESS OTHER _____

DELIVERY DETAILS ☐ NORMAL VAGINAL BIRTH ☐ FORCEPS ☐ VACUUM ASSIST

☐ CESAREAN SECTION ☐ BREECH BIRTH

More Information: _____

_____

_____

_____

_____

CHILD STUDY CENTER

APPOINTMENT REQUEST / SELF REFERRAL FORMS

Patient Name:_____ Date of Birth:_____

CLINICS WITHIN THE SECTION OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

Check this list to ensure the type of service you are needing is available and indicate which clinic you feel would best serve the needs of the child. (Helpful if you know, but not required for processing).

For clinics that are currently unavailable , please check back at a later date. We are working on getting these re-opened.

☐	**A BETTER CHANCE CLINIC (ABC)** Assessments for patients, birth to age 7, for *CONFIRMED EXPOSURE* to drugs and/or alcohol before birth. Includes comprehensive developmental evaluations, behavior management programs, information, coordination with other programs and agencies, and guidance/support to families and caregivers who are raising infants/children considered to be high-risk.
CURRENTLY UNAVAILABLE	**ADHD AND DEVELOPMENTAL-BEHAVIORAL PEDIATRIC CLINIC** Medical evaluations and treatment as needed including medication management for patients, age birth to 18 years, with complex neurodevelopmental disorders including ADHD and other disruptive behavior disorders, autism spectrum disorders, language disorders, and intellectual disability, among others.
CURRENTLY UNAVAILABLE	**BEHAVIOR CLINIC AND PARENT CHILD INTERACTION THERAPY (PCIT)** Assessment and treatment services for children and adolescents with a wide variety of emotional and behavioral problems.
☐	**CHILD GUIDANCE SERVICES** Developmental and Autism screenings, speech/language/hearing assessments, and behavioral consultation, evaluation, and therapy, parenting classes, support groups, and individual consultation, child care mental health consultation, resources, and referral services.
☐	**CHILD TRAUMA SERVICES (CTS)** Assessment and treatment, age 3 and up, and families impacted by trauma. Includes child trauma assessment and Trauma-Focused Cognitive -Behavioral Therapy (TF-CBT).
☐	**DEVELOPMENTAL DELAY AND PSYCHOEDUCATIONAL EVALUATION CLINIC** Evaluations age 6 to 18 with concerns regarding developmental delays, behavior, and academic achievement.
CURRENTLY UNAVAILABLE	**JUMPSTART / AUTISM EVALUATION CLINIC** Evaluations for children age 6 years 11 months old and younger with suspected autism spectrum disorders.
☐	**OCCUPATIONAL THERAPY EVALUATION** Assessments for birth to 18 years for fine/gross motor development, pre-writing/writing skills, visual motor skills, self-care daily tasks, sensory integration, and social skills.
CURRENTLY UNAVAILABLE	**PEDIATRIC NEUROPSYCHOLOGY CLINIC** Comprehensive neuropsychological evaluations for patients age 2 to 18 with medical, neurological, and/or neurodevelopmental disorders.
☐	**PROBLEMATIC SEXUAL BEHAVIOR PROGRAM** Outpatient clinical program for children age 3-12 who are exhibiting problematic sexual behavior & for boys age 13-18 with illegal sexual behavior.
CURRENTLY UNAVAILABLE	**SPECIALIZED ASSESSMENT CLINIC** Psychological evaluations for children ages 5 and older for a variety of problems such as Autism, ADHD, Emotional/Behavioral disturbances, and learning disabilities. Clinic also provides outpatient Cognitive Behavior Therapy services. This is NOT a medical evaluation.