



Advanced Pediatric Associates^{LLP}

5657 S. Himalaya, #100
Centennial, Colorado 80015
303.693.1404
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13650 E. Mississippi Ave., #110
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Administrative Office
5657 S. Himalaya, #100
Centennial, Colorado 80015
720.870.4740
720.974.7175 Fax

Michael L. Kurtz, M.D.

Lee S. Thompson, M.D.

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Stephanie S. Stevens, M.D.

Bradley D. Kurtz, D.O.

Jeanne Oh, M.D.

Jill Kramer, M.D.

Natalia M. Prada, M.D.

Suzanne L. Rogers, D.O.

Nancy J. McDermott, M.D.

Date: _____

Child's Name: _____

Date of Birth: _____

Dear Parent:

Because ADD/ADHD is a chronic condition requiring ongoing medication, it is our policy to follow your child every 6 months to monitor his or her progress and growth. Our records indicate that it has been 6 months or more since your child's last medication evaluation visit. Consequently, a new evaluation is required before a prescription can be refilled or issued.

Enclosed please find questionnaires for you as well as your child's teacher(s) to complete. If your child is of middle school age or older, it is necessary to have completed questionnaires from at least two teachers. Please return the questionnaires to us. After the forms have been received and reviewed by the Provider, we will contact you to schedule an appointment for a medication evaluation.

Please be aware, there are additional charges involved in the scoring and evaluation of these questionnaires. These charges will be added to the office visit charge on the date of the visit.

Thank you for your cooperation. In the meantime, please do not hesitate to call, (720) 974-7188, if you have questions regarding this process. We look forward to working with you.

Sincerely,

ADD Specialist

Enclosures

Please return this letter with the completed questionnaires. Thank you!

For internal use only:	
Appointment:	
Packet reviewed by:	
Time spent in Review:	Time Required for Appt:



Advanced
Pediatric
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FOLLOW-UP ADHD QUESTIONNAIRE FOR PARENTS

Parent Name _____ Date Completed _____

Child's Name _____ DOB: _____ Time Completed _____ am pm

Name of medication (if any) _____ (brand name or generic)

Current dosage schedule: 1st dose - _____ mg at _____ am pm (circle one)

2nd dose- _____ mg at _____ am pm

3rd dose - _____ mg at _____ am pm

1. What problems does your child present at this time?

2. What changes have there been, if any, since the last time this report was completed?

For the better: _____

For worse: _____

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

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her 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. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing 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 noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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Date: _____

Child's Name: _____

Date of Birth: _____

Dear Teacher:

Because ADD/ADHD is a chronic condition requiring ongoing medication, it is our policy to follow children on medication every 6 months to monitor their progress and growth.

Please complete the enclosed questionnaires and return the questionnaires to the child's parent. If you have any questions regarding the questionnaires or this process, please do not hesitate to contact one of our ADD coordinators at 720-974-7188.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

ADD Coordinator

Enclosures

Please return this letter with the completed questionnaires. Thank you!

For internal use only:	
Appointment:	
Packet reviewed by:	
Time spent in Review:	Time Required for Appt:



FOLLOW-UP ADHD QUESTIONNAIRE FOR TEACHERS

Child's Name _____ Date Completed _____

Teacher's Name _____ Subject Taught _____

1. Did you complete an initial report on this child? ____ No ____ Yes

If no, how long have you known this child? _____

Daily average of hours with child: _____

2. What problems does the child present at this time?

3. What changes have there been, if any, since the last time this report was completed?
(Quantitative change in specific academic subjects, e.g., much worse, etc.)

For the better: _____

Subjects: _____

For worse: _____

Subjects _____

Thank you. Please give the completed form to the child's parent for return to our office.

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 last assessment scale was filled out. Please indicate 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. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing 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 noises or other 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 when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

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

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	Are these side effects currently a problem?			
	None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:**For Office Use Only**

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

Fax number: _____

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