Standard 5: Psychological and Social Services

To view examples of standard 5 documentation that Teams have submitted as evidence of compliance of the Standards for Cleft Palate and Craniofacial Teams, please visit: http://www.acpa-cpf.org/standards-examples

5.1 The Team has a mechanism to initially and periodically assess and treat, as appropriate, the psychological and social needs of patients and families/caregivers and to refer for further treatment, as necessary.

33. Describe how the Team identifies patients and families/caregivers who may be in need of further evaluation and treatment for emotional or behavioral issues. The use of a psychologist or social worker is encouraged to serve this function. If another professional serves in this role, please describe his/her qualifications.

Every patient that is referred to the Cleft Palate Craniofacial Clinic at is assessed by the psychologist and social worker on the Cleft Palate Craniofacial Team. The psychological and social work assessments are available at every visit but typically more comprehensive evaluations of cognitive development are done just prior to school entry unless there are concerns by either the parent, the primary physician or any of the members of the Team that there are issues with developmental delay. The social worker offers to see the patients on every visit and is available to help by either a telephone consultation or in person consultation at any time. The psychologist and social worker on the Team are able to access all of the pediatric, adolescent, and adult psychiatric services at which cover all of the potential areas of difficulties that these patients may have. The psychologist and social worker on the Team also have an extensive network of contacts in the surrounding areas in the community if patients or their families prefer to receive any necessary psychological or psychiatric care locally.

34. Attach an example from a patient's team record of a referral for evaluation or treatment of **emotional** or **behavioral** concerns and the resulting report from that evaluation or treatment. If these services are provided internally by a professional listed on the team roster (must be listed on Table 2 of this application), submit a note or report from that provider; documentation of a referral is not necessary. Omit all patient identifying information. Label as 5.1.35 and limit the attachment to ten pages or fewer.

5.2 The Team has a mechanism to assess cognitive development.

35. Describe how the Team identifies patients who may be in need of further evaluation or treatment for cognitive development issues. The use of a psychologist or social worker is encouraged to serve this function. If another professional serves in this role, please describe his/her qualifications.

Any patient who is identified as having any developmental delay is given a comprehensive age appropriate test of development by the psychologist on our Team. In the absence of any concerns about developmental delay on the part of the parents, the community, the provider, the patient's school or any of the Team members, this initial assessment is usually carried out about a year prior to school entry. If problems are identified, recommendations by the psychologist and the remaining members of the Team are made and these are communicated to the parents and as needed with the patient and parents appropriate permission to any

community providers that help with the development of the patient.

36. Attach an example from a patient's team record of a referral for evaluation or treatment of **cognitive development** concerns and the resulting report from that evaluation or treatment. If these services are provided internally by a professional listed on the team roster (must be listed on Table 2 of this application), submit a note or report from that provider; documentation of a referral is not necessary. **Omit all patient identifying information.** Label as 5.2.37 and limit the attachment to ten pages or fewer.

(5.1.35) Attach an example from a patient's team record of a referral for evaluation or treatment of **emotional** or **behavioral** concerns and the resulting report from that evaluation or treatment. Limit attachment to ten pages or fewer & omit PHI.

Supervisory

DEMOGRAPHIC INFORMATION

Age: 7 Y
Birthdate:

Service Date/Time: 04-Apr-2017 10:01
Provider: MD Pager: 4-7505
Service: CAP Type/Desc: SUP Status: Fnl Revision #: 2

REFERRAL

Dr. Pediatric Diagnostic and Referral Clinic.

CHIEF COMPLAINT/PURPOSE OF VISIT

Today, I supervised Dr. who assisted in the evaluation of , a d first grader from . We were asked for opinions and recommendations regarding possible anxiety by Dr. in the Pediatric Diagnostic and Referral Clinic.

IMPRESSION/REPORT/PLAN

Dr. discussed her findings based on her interviews with and her mom. I reviewed the medical record including the very comprehensive note by Dr. dated February 23, 2017, and then I joined Dr. in meeting with and her mom as well. I agree with the impression, report, and plan recorded by Dr. in her initial evaluation note of April 4, 2017.

To summarize, is a very pleasant girl who has been followed in the Craniofacial Clinic. She has developed a marked sensitivity to loud sounds and avoid situations where she might encounter loud sounds such as stores and another situations. If she is not able to avoid these, she might have a meltdown when she is exposed to unexpected loud sounds. She does not do well with transitions that she is not prepared for either. Another area of significant anxieties is around medical appointments and medical procedures. In fact, she was quite concerned that she would have to have her blood pressure rechecked this morning since it did not go smoothly when she had the first attempt. She has some reticence in social situations as well. She seems to like school though, and has an IEP and has speech interventions there. There is some concerns about distractibility as well, but she does not seem to be particularly impulsive or overactive.

Dr screened for some other possible concerns as well, and we do not see significant concerns regarding depression, autistic spectrum disorder, or even reactive attachment disorder. Instead, we diagnosed a specific phobia to loud noises and medical providers and procedures and feel that she may also have social anxiety. At this point, we would consider the inattentive ADHD diagnosis as a "rule out," to be reassessed after she has had the opportunity to effectively address the anxiety symptoms.

Dr. and I recommended that she have an evaluation in the Anxiety Clinic and discussed treatment options available in that clinic. Dr. referred her and will follow up with her after several treatment sessions. We may want to get some Connors or Vanderbilt ADHD rating scales done before the end of the school year, but after she has had some anxiety treatment.

Please refer to Dr. s notes for additional important details.

DIAGNOSES

#1 Specific phobia (loud noises and medical procedures)
#2 Probable social phobia

Original: mwo/baw

DEMOGRAPHIC INFORMATION

Clinic Number:
Patient Name:
Age:
Birthdate:
Address:

Service Date/Time: 04-Apr-2017 07:44
Provider: MD Pager: 3-5097
Service: CAP Type/Desc: CON Status: Fnl Revision #: 5

REFERRAL

PEDS

CHIEF COMPLAINT/PURPOSE OF VISIT

anxiety

HISTORY OF PRESENT ILLNESS

is a 7 year-old young girl of Chinese descent, adopted at 15 months of age, currently in first grade at Elementary School, residing in with her adoptive family. She has medical history significant for unilateral cleft lip and palate and speech dysarthria. She has been referred to for evaluation regarding anxiety symptoms and sensory difficulties regarding loud toys. presents today with her adoptive mother.

's initially very shy and reticent to engage in interview and non-spontaneous in her speech. She initially makes intermittent eye contact. However, as she becomes more comfortable, she becomes more talkative, interactive, demonstrates improved eye contact, and more spontaneous in her speech. Her speech is noticeably dysarthric and difficult to understand, and her mother notes difficulties at times understanding her speech. is quite ruminative and worried about the fact that her blood pressure will need to be still attained. Her mother reports she has specific phobia regarding going to medical appointments and becomes very distressed and ruminative on possible interventions and will focus on it for days in anticipation of the appointment. For example, her mother pointed out that is already worried about when she will get a flu shot next winter season.

Her mother reports that has great sensitivity with loud noises such as toys, toilets, or certain environments (stores such as Walmart or Target or basketball games). She becomes distressed in anticipation of a possible loud noises. She will initially put her hands to her ears but subsequently progress to getting upset, crying, and requesting to leave the situation. She also becomes anxious about possibility of a loud noise when going to places outside the home. Mother reports she has difficulty with transitions or unplanned events. She does not have other sensory sensitivities and per her mother eats most foods.

eports feeling at times that the kids are school can be "bossy" and tell her what to do. She desires social interaction, stating she would like to have sleep over with 6 kids from her school for her birthday this year in November. However, she has difficulties verbally communicating her needs to those around her and her speech is difficult to understand which may make her feel different and self-conscious. At school and at SACC, where there are groups of kids, she is reclusive, hesitant to initiate social interactions, and avoidant of group social situations. However, at home, she is more expressive, creative, and interactive. This was even evident during the interview process where initially she was very shy and reticent to engage and answer questions, but as she became comfortable became more interactive and conversant, made better eye contact, and smiled when discussing things she enjoys doing.

Mother denies history of hand flapping or other stereotypic behaviors. She reports . reciprocates social emotion with her family but is withdrawn in large social situations. There some concerns expressed about possible inattention at school and difficulties staying on task. On the BASC she had elevated scores for anxiety and

PHYSICAL EXAMINATION

Mental:
Appearance: young girl of Chinese descent, wearing glasses, well-groomed, dressed casually, initially intermittent eye contact, but as she became more comfortable with interviewer, she made better eye contact. She has some facial scarring evident from repeat surgeries to fix her cleft palate.
Behavior: initially shy and anxious, but as she became more comfortable she became more interactive and talkative during the course of the interview, no psychomotor retardation or agitation
Cooperativity: overall co-operative
Speech: Initially non-spontaneous, but as she became more comfortable, more spontaneous. Soft spoken. Dysarthric and difficult to understand speech. Normal in rate, tone, and prosody.
Mood: some what anxious
Affect: mood-congruent, stable, appropriately reactive to conversational content
Thought content: no evidence of delusions or abnormalities; ruminative about whether she will have to get vital signs done
Thought process: grossly linear and goal directed and consistent with her developmental age
Consciousness: awake and alert
Orientation: oriented to person, place and time
Memory: intact, as evidenced by ability to demonstrate accurate historical recall for recent and more remote events during discussion
Attention: intact, able to follow flow of conversation with no significant impairment
Fund of Knowledge: consistent with education and experiences as evidenced by vocabulary
Safety: denies suicidal ideation, intent or plan; denies passive death wishes; denies homicidal ideation

IMPRESSION/REPORT/PLAN

's a 7 year-old young girl of Chinese descent, adopted at 15 months of age, currently in first grade at Elementary School, residing in with her adoptive family. She has medical history significant for unilateral cleft lip and palate and speech dysarthria. She has been referred to for evaluation regarding anxiety symptoms and sensory difficulties regarding loud toys. presents today with her adoptive mother.

s history, neuropsychological testing, and clinical presentation support Specific Phobia (loud noises and medical procedures) and Social Phobia. She has never had therapy to address these anxiety disorders. No history of exposure for CBT with ERP. Additionally, dysarthric speech makes it difficult to communicate with others which my be contributing to social anxiety and social withdrawal she is exhibiting. She currently receives speech therapy at school. She has no history of psychotropic medications. We review and discuss the anxiety cycle and role of therapy with hierarchy of exposures. We also review role of medications if is unable to meaningfully engage in therapeutic interventions. We review referral to the Anxiety Clinic for evaluation for possible participation in either Anxiety Group or the Intensive Anxiety Program. There some concerns expressed about possible inattention at school and difficulties staying on task. On the BASC she had elevated scores for anxiety and attentional problems. However, her anxiety may be confounding. It would be helpful to repeat assessments later this year with Vanderbilt screening tool (targeting ADHD) and BASC and try to get treatment for her anxiety symptoms.

Plan:
1. We will refer or evaluation by the Anxiety Clinic. She may benefit from participation of age appropriate Anxiety Group or possibly the Anxiety Intensive. l history, neuropsychological testing, and clinical presentation support Specific Phobia (loud noises and medical procedures) and Social Phobia. She has never had therapy to address these anxiety disorders. No history of exposure for CBT with ERP.
2. No medications needed at this time. She has no history of psychotropic medications. We review and discuss the anxiety cycle and role of therapy with hierarchy of exposures. We also review role of medications if l is unable to meaningfully engage in therapeutic interventions.
3. There some concerns expressed about possible inattention at school and difficulties staying on task. On the BASC she had elevated scores for anxiety and attentional problems. However, her anxiety may be confounding. It would be helpful to repeat assessments later this year with Vanderbilt screening tool (targeting ADHD) and BASC and try to get treatment for her anxiety symptoms. We will plan to distribute forms this May.

4. I provided s mother my business card and encouraged her to call if she has any questions concerns. We will plan for follow up appointment on May 25, 2017 at 3 PM.
5. I reviewed with the patient and her mother the availability of emergency psychiatric resources. In the event of an emergency, such as inability to care for self, suicidality, homicidality, or marked concern about safety, I recommended that the they phone either 911, national suicide prevention life line (1-800-273-TALK), or present to the nearest emergency department for evaluation. The patient was able to articulate an understanding of this recommendation.

DIAGNOSES

#1 Specific phobia (loud noises and medical procedures)
#2 Probable social phobia
#3 rule out ADHD combined type

Original: sg/mbs revised by sg
Electronically Signed: 07-Apr-2017 12:25 by MD

Neuropsychological Assessment – Child

Psychology

Provider: PhD, LP Service Date/Time: 23-Feb-2017 10:08

Testing (hrs) NPST Service Code PAL Years 7 Months 3 Gender: Female Grade 1 Handedness Right

Person Requesting Evaluation

Reason for Referral Neuropsychological screening within context of craniofacial clinic visit.

Professional Time 120 Technician Time 120 Computer Time

History of Present Illness

is a now 7-year-old right-handed adopted Asian female with a history of repaired unilateral cleft lip and palate is currently undergoing her annual multidisciplinary workup and Craniofacial Clinic visit This is third psychometric assessment. Clinical interview was conducted with her mother.

was first assessed when she was roughly 3-1/2 years of age. Parent-completed questionnaires revealed no behavior/emotional concerns or, for that matter, any difficulties with adaptive functioning (e.g., self-care, communication, and social skills). Early academic screening in the form of letter, color, and shapes was in the high average range (Bracken). nonverbal abilities assessed with pattern matching or identifying objects was very strong with scores in the average to superior range overall In contrast, it has been documented with a speech pathology consultation struggled with expressive and receptive language skills (DAS verbal cluster standard score = 74).

During last assessment in the fall of 2015, there are two areas of concern that warranted monitoring but not necessarily treatment. First, had variable attention abilities. Additionally, there were some emerging concerns regarding anxiety and avoidance of some social interactions.

developmental and medical histories have been thoroughly documented in her medical record and will only be briefly summarized. now wears glasses, but there is no obvious impairment with vision. Hearing is deemed normal. With melatonin, sleeps through the night. She does not snore or is considered excessively restless. She does not take naps during the day and does not comolain of fatigue. will eat a limited range of food does not think this is necessarily due to avoidance of certain textures, rather tends to stick to foods that she knows and is avoidant of trying new items

As been mentioned by several providers, has developed an increasing sensitivity to loud sounds. She has become more avoidant of settings with loud sounds or where there is the anticipation of noisiness. She has been observed in her after school program sitting by herself with her hands over her ears. The family has attempted to use headphones to help also points out that typically the first thing does when she comes home from school is use the bathroom. She questions if is apprehensive about using the toilet at school due to the excessive noise has no other sensory aversions outside of her reticence to wear jeans. is not certain of this is texture related

is currently in the first grade at Elementary School. She is on an IEP with a speech language impairment classification. She receives speech intervention twice weekly She has just recently begun Title I math services. There are no disruptive behaviors at school Some days seems resistant to leaving home to go to school. It has also been reported that she is not a willing participant in classroom activities. During recess, she tends to keep to herself There is some question if s being bullied at school.

In terms of academic skills, spelling is deemed normal. It is perception that is slower to learn math facts compared to other children her age For reading, she has little difficulty learning oral nursery rhymes She tends to skip words when reading out loud Her reading speed is deemed to be on the slow side. In reviewing her progress report, it appears that is in the beginning first grade level for comprehension.

Cognitively, teachers this year report more concerns regarding her focus and concentration, and notices the same type issues in the home setting. However, at other times, can focus very appropriately particularly on activities of interest. She typically can follow two-step oral instructions needing reminders for larger step directives. is inconsistently active and impulsive. She is generally a restless child who has great interest in jumping and bouncing as well as swinging. Outside of mathematics, there are no concerns with her memory Penmanship is deemed "not good" but legible. feels uses an unusual "pencil grip." She has no issues with utensils or tying her shoes She needs occasional assistance with zippers and buttons

With regard to behavior/emotional functioning, issues of depression, excessive irritability, significant problem behaviors or past/current inappropriate touching or abuse were all denied. does perceive to have a fair amount of anxiety. First, as mentioned, has great sensitivity with loud noises such as toys, toilets, or certain environments (store). It appears that the family has done some basic exposure therapy to try to get comfortable in these distressing settings This has had some, but not necessarily significant benefit. continues to be somewhat apprehensive about medical procedures and appointments. Yesterday, had an orthodontics appointment. The had to do preparatory coaching and role playing with before the appointment. also pointed out that is already worried about when she will get a flu shot next winter season. Finally there are some questions about social anxiety. typically prefers to be by herself or at home. In the home setting, she is generally much more expressive, creative, and interactive. In contrast, in public, she is more reclusive, hesitant, and withdrawn. Her main interaction is with her brother . When she is comfortable, has appropriate social skills. She readily shares and takes turns. She can easily pick up on the emotional experiences of others.

Since I last saw the , there have been no changes in family dynamics or stressors.

Current Medications

melatonin tablet 1 tablet by mouth every bedtime.
Indication, Site, and Additional Prescription Instructions:
1.5 mg

multivitamin with iron tablet 1 tablet by mouth one time daily

These are the patient's medications as of Thursday, February 23, 2017 at 11:37 AM.

Impression / Report / Plan

EVALUATION PROCEDURES
Relevant information was obtained from the patient's medical record and interviews with caregivers. Parents completed several behavioral questionnaires.

(continued)

Neuropsychological Assessment – Child

Psychology

Provider: PhD, LP Service Date/Time: 23-Feb-2017 10:08

(continued)

I explained to that a more conservative approach would be to first treat anxiety. Often times, children who are anxious have compromised attentional abilities as their emotional distress makes it difficult for them to focus. If attentional difficulties persist after anxiety is lessened, this would suggest may also have ADHD and in need of treatment for this issue as well. A second approach would be to treat both anxiety and ADHD concurrently if the diagnosis is supported once I receive teacher forms.

RECOMMENDATIONS:

Behavior/Emotional Functioning

As mentioned will be undergoing a Psychiatry evaluation in a matter of weeks. I defer to my colleagues about specific recommendations concerning medication. I do wonder if and her family would benefit from treatment in our Anxiety Disorders Clinic. As mentioned, I already provided them patient education materials about the type of treatment this clinic provides.

ADHD/Attention

Suggested educational accommodations for students with attention problems include the following:

a. Preferential seating is recommended as much as possible. The student should be seated away from doors, windows, and noisy areas. Seating arrangements close to the teacher would be optimal.

b. Slow rate of presentation of materials and instructions, repeat instructions, summarize frequently.

c. Be sure that directions are clear, simply stated, and given one at a time. Deliver more complex directions in brief, simple numbered steps (e.g., first, read pages 1 to 10; second, answer questions 1 to 5; and third, check answers in the back of the book). If continues to have difficulty, write down key instructions, provide a visual map, and attach them to desk in order to cue.

d. Provide consistency and structure through the use of daily schedules, standard seating arrangements, and clearly define classroom expectations, rules, and consequences.

e. Provide regular feedback with some helpful concrete suggestions for appropriate behaviors.

For general information on attention deficit hyperactivity disorder, the ADD Warehouse at www.addwarehouse.com provides a comprehensive catalog of books, tapes, and training materials. The national web site of CHADD (Children and Adults with Attention Deficit Hyperactivity Disorder) also has valuable information for parents and teachers (www.chadd.org). The Help4ADHD.org website may also be useful.

Useful books include:

"Taking Charge of ADHD: The Complete, Authoritative Guide for Parents" by Russell Barkley.

"Parenting Children with ADHD: Ten Lessons that Medicine Cannot Teach" by Vincent J. Monastra

"Parenting that Works: Building Skills that Last a Lifetime" by Edward Christophersen and Susan L. Mortweet.

There is emerging literature on the effectiveness of exercise on attentional ability. I provided the family with an article on this topic.

Reevaluation

I suggest retesting in 12 months time.

Diagnosis

#1 Repaired unilateral cleft lip and palate

#2 Anxiety disorder (specific phobia and separation anxiety)

#3 Rule out ADHD combined type

Key

RS = Raw Score AE = Age Equivalent GE = Grade Equivalent SS = Scaled Score StdS = Standard Score PR = Percentile T = T-score
DH = Dominant Hand NDH = Non-Dominant Hand Z = Z-score D/C = Discontinued

Intellectual Functioning

☐ See section "Other Tests"

Test: Differential Ability Scales – II (DAS-II) Upper Years

Subtests	RS	T	PR	AE
Verbal Comprehension	13	41	18	5:10
Naming Vocabulary	12	61	86	Above 8:10
Picture Similarities	6	38	12	4:10
Matrices	7	40	16	5:4
Pattern Construction	19	51	54	7:4
Copying	14	50	50	7:4

Clinic (5.2.37) Attach an example from a patient's team record of a referral for evaluation or treatment of cognitive development concerns and the resulting report from that evaluation or treatment. Limit attachment to ten pages or fewer & omit PHI.

5-Jun-2015 Outpatient Orders

Demographic Information:
Clinic Number:
Patient Name:
Age:
Order Date: 16-Jun-2015 16:06

Birthdate: [redacted] Sex: M
Address:

Order Description
Psych Ped Test (w/Medical Complication)
Indications: Apert's Syndrome (Q87.0)

Clinical question to be answered
CFC: Apert's syndrome

Signing/Scheduling Information
Ordered By:
Signed By:
Entered By

Neuropsychological Assessment – Child
Psychology

Provider. PhD, LP Service Date/Time 27-Aug-2015 09:42

Testing (hrs) NPST Service Code PAL Grade PK Handedness Right

Person Requesting Evaluation

Reason for Referral Neuropsychological screen within context of Craniofacial Clinic visit.

Professional Time 90 Technician Time 120 Computer Time

History of Present Illness

is an adorable, ıld, mixed-handed Caucasian male. is currently undergoing his annual multidisciplinary Craniofacial Clinic visit. In reviewing his medical record, this appears to be first psychometric assessment. Clinical interview was conducted with his father.

developmental and medical histories have been thoroughly documented in his medical record and will only be briefly summarized. was the product of a 36-week gestation delivered via cesarean section due to breech presentation. Apert syndrome was diagnosed by amniocentesis. eveloped external hydrocephalus after cranial vault remodeling in the fall of 2011. He subsequently has received a right-sided ventriculoperitoneal shunt. After a Sleep Medicine consult. was diagnosed with periodic limb movement disorder and upper airway resistance syndrome but with no sleep apnea. Additionally, he has low ferritin. E. has suggested that a tonsillectomy be completed. In terms of other salient medical history, began to develop headaches with subsequent vomiting which started in the fall of 2014. It was thought that this may be due to his shunt malfunctioning. However, repeated imaging has not indicated such issues. ast visited in Pediatric Neurology in April 2015. Imaging was conducted which was not concerning for enlargement of the ventricles. The Heindels understand that ongoing issues with headaches and vomiting may be a function of migraine headaches.

has no concerns with vision, appetite, or hearing He has no significant nighttime awakenings and gets at least ten hours of sleep nightly. He is not considered an overly restless child when he sleeps On average, two to three times per week he will take a nap of upwards of two hours' duration

According to has not received any early childhood special education services. is currently in a preschool setting. He has received Mayo-based occupational therapy after elbow and hand surgery. anticipates that occupational therapy will restart in the fall to address more fine motor concerns. as received speech therapy once monthly as I understand it. Based on the speech pathology consultation yesterday, it has been suggested that he receive interventions once weekly

In the areas of preacademic skills development, as basic color and shape recognition. He can say the alphabet in its entirety with occasionally missing the order of the letters J and K. He can recognize all letters both upper and lower case. He easily catches on to various song lyrics At this stage, he is working on individual letter-sound correspondence. can spontaneously count to at least 30. He can count with one-to-one correspondence up to five. He recognizes the numbers 0 through 9. His understanding of quantitative concepts such as more or less, or larger or small, is solidifying. He can sort items by color and shape In terms of fine motor skills, can occasionally spontaneously write the letter "Z" and with some directions the letter "E." He can make some semblance of a horizontal line, vertical line, and circle. has some questions if can draw a triangle. He is unable to draw a square He can make some semblance of a stick person but not a face with decipherable eyes, nose, and mouth. attempts to color within the lines. He is not yet using safety scissors. He holds a writing utensil with his thumb and index finger only, fully straightened.

Cognitively, there no marked behaviors consistent with an ADHD presentation. was uncertain how many step directions he could follow. He does not detect any obvious learning or memory concerns in his son. Finally, in the area of fine motor skills does use a fork, spoon, and cup If a zipper is started for him, he can zip and unzip articles of clothing. On the other hand, buttons are described as "impossible."

With regard to behavior/emotional functioning, .s described as a generally extremely happy and engaging young man. Issues of depression, anxiety, excessive irritability, significant problem behaviors, odd/unusual behaviors, or inappropriate touching/abuse were all denied.

does not have a significant negative reaction to transitions or unexpected changes in routine. He has no dramatic adherence to nonfunctional routine or repetitive mannerisms He does not engage in complex body movements when excited or distressed He has a variety of age-appropriate interests such as coloring, watching TV shows, and being read to. He has a very vivid imagination.

Socially, is very affectionate. He does pick up on the emotional experiences of others and will offer comfort when he sees someone injured or upset. He shows a variety of facial expressions and emotions consistent with the situation at hand. He easily combines gesturing with his communication He will show and bring objects of interest to others. He can initiate and maintain social exchanges He will follow the pointing of others as well as direct others to distant objects ' does wish eye contact was more consistent.

Outside of managing complex medical conditions, there are no other underlying stressors in the home environment. There have been no recent adverse changes at home

Current Medications

Cuvposa 1 mg/5 mL (0.2 mg/mL) solution 1-2 mL by mouth three times a day.
Indication, Site, and Additional Prescription Instructions:
Give 1 ml three times daily for 7 days then increase to
2 ml three times daily after the 7 days.

Nasonex 50 mcg/actuation spray 1 spray nasally one time daily.
Instructions: One spray in each nostril
Indication, Site, and Additional Prescription Instructions:
One spray in each nostril

pediatric multivitamin-Fl chewable tablet 1 tablet by mouth one time daily.

These are the patient's medications as of Tuesday, September 8, 2015 at 9.02 AM.

Impression / Report / Plan

EVALUATION PROCEDURES.
Relevant information was obtained from the patient's medical record and interviews with the patient and caregivers. Parents completed several behavioral

(continued...)

Neuropsychological Assessment – Child
Psychology

Provider: PhD, LP Service Date/Time: 27-Aug-2015 09:42

Subtests	RS	T	PR	AE
Verbal Comprehension	12	46	34	3:10
Naming Vocabulary	18	47	38	3:10
Picture Similarities	18	48	42	4:1
Matrices	9	59	82	6:1
Pattern Construction	13	55	69	4:10
Copying	12	51	54	4:4

Cluster	Sum of T	StdS	PR
Verbal	93	94	34
Nonverbal Reasoning	107	107	68
Spatial	106	105	63
GCA	306	102	55
SNC	213	106	66

Academic Achievement ☐ See section "Other Tests"

Wechsler Individual Achievement Test – 3rd Edition (WIAT-III)

Subtests	RS	StdS	PR	GE	AE
Listening Comprehension	—				
Early Reading Skills					
Reading Comprehension					
Math Problem Solving					
Alphabet Writing Fluency					
Sentence Composition	—				
Word Reading					
Essay Composition	—				
Pseudoword Decoding					
Numerical Operations					
Oral Expression	—				
Oral Reading Fluency					
Spelling					
Math Fluency-Addition					
Math Fluency-Subtraction					
Math Fluency-Multiplication					

Supplemental Subtest Score Summary	RS	StdS	PR	GE	AE
Essay Composition:Grammar & Mechanics					
Oral Reading Accuracy					
Oral Reading Rate					

	StdS	PR
Sentence Composition		
Sentence Building		
Sentence Combining		
Essay Composition		
Word Count		
Theme Development & Test Organization		
Composite		
Oral Language		
Total Reading		
Basic Reading		
Reading Comprehension & Fluency		
Written Expression		
Mathematics		
Math Fluency		
Total Achievement		

Informant Information Administered ☐ See section "Other Tests"

Behavior Assessment System for Children (BASC) Ages 2-5

(5.3.38) If applying as a CFT, provide an example that cognitive psychometric testing has been performed on a patient who is age 4 or older & has a craniofacial condition requiring transcranial surgery. Include results of the testing along with the name and specialty of the person performing the test. Limit attachment to 10 pages & omit PHI.

Neuropsychological Assess
Psychology

Provider: PhD, LP Service Date/Time 18-Dec-2014 09:50

Testing (hrs) NPST Service Code PAL Handedness Right

Person Requesting Evaluation Neuropsychological screen within context of multidisciplinary CFC visit

Reason for Referral

Professional Time 121 Technician Time 120 Computer Time

History of Present Illness

is a now 9-year-old, right-handed, Caucasian male. He is currently undergoing his annual multidisciplinary CFC visit. He has been previously assessed in October 2009 by Dr. in September 2011 by Dr and myself in November 2012. I had the opportunity to review his medical record. Clinical interview was conducted with caregivers.

developmental and medical histories have been thoroughly documented in his medical record and will not be summarized in total s a twin. He has a history of scaphocephaly with premature fusion of his sagittal suture He has undergone surgical correction for the craniosynostosis Both and his twin were born at 30 weeks gestation. There have been some concerns in the past about behaviors suspicious for seizures (staring spells) However, EEG studies were interpreted as showing no epileptogenic activity. There are no concerns with vision, hearing or appetite. reports . snores frequently and is a very restless sleeper. She estimates he is getting roughly 10 hours of sleep per night

As previously mentioned, has undergone three previous evaluations.

During his initial evaluation he was 3 years 11 months of age. There was no evidence of cognitive or behavior/emotional issues at that time.

The next evaluation occurred when he was 5 years old. This testing revealed issues with fine motor coordination (copying geometric shapes), with performance in the borderline range (DAS-II, copying subtests, T-score = 35). Low average performance was noted in regard to math problem solving (standard score = 85) and alphabet writing fluency (standard score = 88) on the WIAT-III. Parent-completed questionnaires revealed significant concerns regarding ADHD, aggression, anxiety, and depression

During the 2012 evaluation there was not significant evidence of any impairment in either thinking skills or fine motor abilities. However, struggled significantly with attentional capacity, both evident in observing him and with formal test scores. Based on this finding, in conjunction with parent-completed questionnaires and teacher-completed questionnaires, I was comfortable providing a diagnosis of ADHD I also provided the family with a number of recommendations for parent management training given behavioral outbursts.

s currently enrolled in the third grade in a public school setting He does not have a formal accommodation or modification plan at school. However, he does get a variety of informal services. For example, he is intermittently allowed preferential seating depending on his mood and behavior. His teacher has also provided a different desk that apparently minimizes distraction and overactivity. If I understand correctly, last year would check-in in the morning and the afternoon with the school counselor. If he had a good day, he was given some sort of incentive or reward. It is [illegible] understanding that this plan is no longer in place. reportedly is having daily meltdowns and outbursts. He becomes tearful if he does not get his way He can be very bossy with peers If he is then ignored, he will have a tantrum. He will invade other's personal space and spontaneously offer hugs and kisses, even when they are not wanted. He tends to do better in small group settings There are no concerns with bullying.

With regard to academic achievement, there are no issues with reading, to include single word reading, decoding unfamiliar words, fluency, or comprehension. Both math calculation and math problem-solving skills are developing at a very nice rate. There are no concerns with spelling.

At the start of the current school year, was having pronounced behavior problems. then contacted the local pediatrician who prescribed what appears to be short-acting methylphenidate at 5 mg. has sporadically taken this medication without pronounced effectiveness. notes that he does not like the taste of the pill also wonders if he is self-conscious about having to take a medication to address behavior. Even when medicated, he had great struggles with attention and concentration. He is extremely active and impulsive to the point that there are concerns about his safety. He can only follow two-step oral instructions He frequently loses objects around the home. There are no apparent long-term memory concerns Penmanship is messy and illegible . has no difficulty with zippers or buttons but struggles with utensils He is a very messy eater. He still cannot tie his shoes or ride a bike.

With regard to behavior/emotional functioning, last year participated in a bout of neuro feedback at a local counseling center did not perceive dramatic change in his behavior. He does meet with a guidance counselor at school roughly every two weeks. There are no concerns with depression, anxiety, or excessive irritability. denies having any significant problem behaviors. She is unconcerned about any past/current abuse. He maintains a variety of age-appropriate interests

Since I last saw the family, there have been numerous stressors in the home environment. is now the primary caretaker for four children The boys continue to have very rare contact with their biological father and only some sporadic contact with their stepfather. There is understandable stress running a single-parent household. There have also been ongoing stressors with chemical dependency in parental figures.

Current Medications

Child's Multivitamins chewable tablet 1 tablet by mouth one time daily.

MiraLAX 17 gram/dose Powder by mouth one time daily.
Indication, Site, and Additional Prescription Instructions:

1 tsp

These are the patient's medications as of Thursday, December 18, 2014 at 11:37 AM.

Impression / Report / Plan

EVALUATION PROCEDURES.
Relevant information was obtained from the patient's medical record and interviews with caregivers. Parents completed several behavioral questionnaires. Corresponding teacher questionnaires were given to the parents for distribution at school. This information was supplemented by detailed observation of behavior throughout the course of this evaluation and of performance on a variety of psychological tests. The tests and scores are listed at the end of this report. Only

[continued...]

Neuropsychological Assessment – Child
Psychology

Provider: hD, LP Service Date/Time: 18-Dec-2014 09:50

(continued)

pages 1 to 10; second, answer questions 1 to 5; and third, check answers in the back of the book). If continues to have difficulty, write down key instructions, provide a visual map, and attach them to Johnny's desk in order to cue ,
d. Provide consistency and structure through the use of daily schedules, standard seating arrangements, and clearly define classroom expectations, rules, and consequences.
e. Provide regular feedback with some helpful concrete suggestions for appropriate behaviors.

4. For general information on attention deficit hyperactivity disorder, the ADD Warehouse at www.addwarehouse.com provides a comprehensive catalog of books, tapes, and training materials. The national web site of CHADD (Children and Adults with Attention Deficit Hyperactivity Disorder) also has valuable information for parents and teachers (www.chadd.org).

Useful books include:
"Taking Charge of ADHD: The Complete Authoritative Guide for Parents" by Russell Barkley
"Parenting Children with ADHD: Ten Lessons that Medicine Cannot Teach" by Vincent J. Monastra
"Parenting that Works: Building Skills that Last a Lifetime" by Edward Christophersen and Susan L. Mortweet

Children with ADHD usually benefit from some form of structured management in the home and school setting. Successful behavior management methods can range from informal approaches such as modifying the frequency and nature of positive and negative feedback to the child by a skilled teacher in the classroom, to more formal methods such as token or point reward systems. Essential components of any behavior management program for should include targeting specific positive behaviors to be increased through the use of rewards, the use of precision commands, noncontingent quality time with parents, a greater frequency of positives (e.g., praise, rewards) than reprimands, and consistent use of negative consequences that are delivered in an emotionally neutral manner for selected inappropriate behaviors. A useful book is Rewards for Kids! Ready-to-Use Charts & Activities for Positive Parenting by Virginia M. Shiller, PhD, with Meg F. Schneider

Medical Follow-up
is interested in follow-up in Pediatric Neurology and potentially a Sleep Medicine consult as well. I told her I would relay this request on to Dr

ADDENDUM (1/25/14). Teacher forms returned after clinic visit and addended. Clinical impressions and recommendations remain the same. Teacher forms note issues with social withdrawal. ADHD issues also noted but not to the level of parent forms.

Diagnosis

#1 Sagittal craniosynostosis
#2 ADHD
#3 Fine motor incoordination

Key

RS = Raw Score AE = Age Equivalent GE = Grade Equivalent SS = Scaled Score StdS = Standard Score PR = Percentile T = T-score
DH = Dominant Hand NDH = Non-Dominant Hand Z = Z-score D/C = Discontinued

Intellectual Functioning ☐ See section "Other Tests"

Test: Wechsler Abbreviated Scale of Intelligence (WASI)

Subtests	RS	T
Vocabulary	39	60
Block Design	8	41
Similarities	29	65
Matrix Reasoning	22	56

StdS	IQ	PR
Verbal	120	91
Performance	97	42
4 Subtest IQ	109	73
2 Subtest IQ		

Neuropsychological Assessment – Child
Psychology

Provider: hD, LP Service Date/Time: 18-Dec-2014 09:50

	RS	SS	PR
Condition 1	32	11	63
Condition 2	50	11	63
Condition 3	60	9	37
Condition 4	166	8	25
Condition 5	43	10	50

Verbal Fluency

	RS	SS	PR
Letter Fluency			
Category Fluency			
Total Correct Responses			
Total Switching Accuracy			
Set-Loss Errors			
Repetition Errors			

Design Fluency

	RS	SS	PR
Condition 1			
Condition 2			
Condition 3			

Color Word Interference Test

	RS	SS	PR
Condition 1			
Condition 2			
Condition 3			
Condition 4			

	RS	SS	PR
Confirmed Correct Responses			
Free Sorting Description			
Sort Recognition			

Twenty Questions

	RS	SS	PR
Initial Abstraction Total Score			
Total Questions Asked			
Total Weighted Achievement			

Word Context Score

	RS	SS	PR
Total Consecutively Correct			

Tower Test

	RS	SS	PR
Total Achievement Score	11	8	25
Total Rule Violations	13	—	4
Mean First Move Time	2.1	13	84
Time per Move Ratio	3.7	11	63
Move Accuracy Ratio	2.2	6	9

Proverb Test

	RS	SS	PR
Free Inquiry			
Multiple Choice			

Attention / Concentration ☐ See section "Other Tests"

Barkley Observation

Behavior	PR
Off Task	
Fidgeting	
Vocalizing	
Plays w/ Objects	
Out of Seat	
Other	

Conner's CPT-II

	T
# Omissions	47.95
# Commissions	59.04
Hit RT	55.77
Hit RT Std Error	64.09
Variability	60.06
Detectability	54.66

PASAT

RS	Ed. Factor	ATS	PR

Informant Information Administered ☐ See section "Other Tests"

Behavior Assessment System for Children (BASC) Ages 6-11