Medical Screen - TheraSuit®

Date:_____

Patient name: _____ Date of birth:_____

Primary Diagnosis: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____State: _____Zip:_____

Home Phone: ( )_____Cell Phone: ( )_____

Parent/Legal guardian: _____

Relation to patient: _____E-mail: _____

Primary language: _____ Interpreter needed: ☐ Yes ☐ No

Additional contact person: _____Phone: ( ) _____

Primary care physician: _____ Referring physician: _____

Specialist(s): _____

Therapy currently receiving: ☐ OT ☐ PT ☐ SLP Where? _____

Date of hip x-ray report (**MUST be no older than 6 months**) _____ ☐ attached

- **Attach any other available test or therapy reports (x-ray, MRI, CAT scans, EMG, PT, OT, etc.)**

MEDICAL HISTORY

1. Diagnoses (List all):_____

_____

_____

2. List any medication your child is taking and reason for taking it:_____

_____

_____

3. Medical / Surgical History:

- Recent surgeries/hospitalizations: _____

_____

_____

- Bone demineralization (Osteoporosis)? _____
- Allergies (Latex? List all): _____
- Botox / Phenol Injections (Dates): _____
- Inhibitive / Serial Casting (Dates): _____
- Fractures/Contractures (Location / dates): _____

_____

- Rhizotomy (Date): _____
- Muscle Lengthening (Location / dates): _____

_____

- Seizures (Severity and date of last one): _____
- Heart Problems / Hypertension / Heart Surgeries: _____

_____

- Breathing / Lung Problems (Is your child on any monitors or oxygen? Tracheostomy? Asthma? Steriods?):

_____

- Diabetes (Type 1 or Type II? Insulin?): _____
- Sensation / Loss of Feeling (Location): _____
- Scoliosis (Location / Degree): _____
- Vision / Hearing: _____ Glasses _____ Hearing Aides _____

_____

- Shunts (Hydrocephalus): _____
- G-Tube / Feeding Problems / Restrictions: _____

_____

- Kidney Problems (Catheterized?): _____

-Other: _____

_____

4. Child's abilities (check what your child can do):

- ❑ Roll over independently
- ❑ Sit independently
- ❑ Assume sitting independently from lying down
- ❑ Crawl
- ❑ Stand:_____ holding on _____independently
- ❑ Walk:_____ holding hands _____independently
- ❑ Other: _____

5. List any medical equipment that your child is utilizing (such as braces / splints, standers, walkers - what type, crutches, canes, wheelchairs, etc.):_____

_____

6. How do you communicate with your child / how do they communicate with you? _____

_____

Can your child follow 1-step commands? ☐ Yes ☐ Sometimes ☐ No

Can your child follow 2-step commands? (for example- first…, then…) ☐ Yes ☐ Sometimes ☐ No

Can your child follow complex commands? ☐ Yes ☐ Sometimes ☐ No

Is your child able to move his or her body parts (for example, arms, legs, head) upon request?

☐ Yes ☐ Sometimes ☐ No

7. What motivates your child? (for example, favorite toys, bubbles, TV, praise)_____

_____

8. What are the patient/family goals the Intensive Strengthening Program?_____

_____

_____

9. Why do you think that this is an appropriate time for your child to have an intensive program? _____

_____

_____

10. Has your child ever been denied therapy at a clinic that provides intensive therapy?

____ Yes _____No (If yes, explain when and why)

_____

_____

When your completed application is received, it will be clinically reviewed. You will be advised of the outcome and the scheduling process will begin. If you have any questions, please contact The Therapy Place (803) 787-3003 and ask for Savannah Fredendall.

Fax this completed form to: The Therapy Place at (803) 787-0300 or

Mail to: The Therapy Place
3620 Covenant Road
Columbia, SC 29204

Parent/Caregiver Signature: _____

Date: _____

If your child is *not currently an active patient at The Therapy Place,* your child will be scheduled for an evaluation. (If your child IS currently an active patient at The Therapy Place, you do not need to schedule an evaluation.)

Evaluations will typically last between 45 minutes to 1 hour. We request the parent/patient arrive 15-20 minutes prior to the scheduled time to complete necessary patient information. We also ask the parent or caregiver to remain present during all evaluations to provide relevant history and information to the therapist as requested. Please bring any previous therapy or discharge paperwork that may be helpful in documenting your child's medical history.

Following the evaluation, the therapist will formally determine the child's eligibility for inclusion in the TheraSuit program. If the child is approved, the parent will be provided with further policy and procedure information and be scheduled for a 3-week session, as able. Following scheduling, the therapist will provide a letter of medical justification for inclusion in the program for pediatrician signature. The parents will be provided with a copy of this letter for any insurance/payment purposes.

Consent for Participation/Informed Consent Waiver

The Therapy Place provides a specialized intensive exercise program, TheraSuit, for children with developmental, neurological, sensory, orthopedic, and other types of disabilities. As one might expect, there is some element of risk involved with any physical activity/exercise, intense exercise program, and the use of all exercise equipment (including the TheraSuit & the Universal Exercise Unit). Although the risk is greatly reduced with the use of safety equipment, proper supervision, training, and a skilled therapist, there still remains the risk of injury during participation in the center's activities.

Therefore, it is necessary to get your permission to allow: _____
(Print patient name)
to participate in the exercise program provided by The Therapy Place.

I, _____ hereby release The Therapy Place and TheraSuit from any
(Parent/Guardian/Patient)

liability, claims, demands, & causes of action, now or in the future, resulting from soreness or injury however caused, occurring during or after my child's participation in the exercise program/suit training session.

Participation in the TheraSuit Method requires various degrees of exercise and movement that may be new to the individual participating. I understand that these activities may result in injury to a person or child and hereby hold harmless The Therapy Place and its staff and volunteers from any injury resulting from the careful and responsible implementation of such activities.

In signing this Consent for Participation/Informed Consent Waiver, I hereby affirm that I have fully read the above statements & understand the inherent risks involved with participation in The Therapy Place's exercise program/suit training session and give permission for my child to participate and for the above interaction between my child and the therapists to take place.

_____ _____
Parent/Guardian/Patient Signature Date

Print Parent or Guardian Name: _____

Emergency Contact Information

Child's Name: _____ DOB: _____

Allergies/Special concerns/instructions (may include seizure instructions, etc.):

_____

_____

CONTACT INFO:
"Primary" Parent/Guardian Name:
_____

Primary Email:
_____

Phone 1: _____ Phone 2: _____

Address:
_____

"Secondary" Parent/Guardian/Emergency Contact Name:
_____

Relationship to Child:
_____

Phone 1: _____ Phone 2: _____

We require that a parent/guardian remain in their car, the waiting room, or close by. Should an emergency occur, and you are not in the present, we will contact 911 and the child will be transported to the Palmetto Health Children's Hospital. A staff member will accompany your child until a parent or guardian arrives. You will be notified immediately.

Name of person filling out form: _____

Relationship to Child: _____

_____ _____
Parent/Caregiver Signature Date:

Parent Release Form for Media Recording

I, _____, do hereby grant/deny permission to **The Therapy Place** to
(Parent/Guardian Name)

use the image of my child, _____, as marked by my selection(s) below. Such
(Child/Patient Name)

use includes the display, distribution, publication, transmission, or other use of photographs, images, and/or video taken of my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on **The Therapy Place** Web site.

❑ **Deny** permission to use my child's image at all.

❑ **Grant** unrestricted permission to use my child's image in connection with **The Therapy Place.** I give unrestricted permission for my child's image to be used in print, video, and digital media. I agree that these images may be used by **The Therapy Place** for a variety of purposes and that these images may be used without further notification. These purposes include, but are not limited to:

- **The Therapy Place Social Media**
- **The Therapy Place print/marketing materials**

I understand that the child's surname will not be used in conjunction with any video, printed, or digital images.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Relationship to Child

If you have any questions about the above, please let staff know.