

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.
When completing this form, please think about your child's behaviors in the past 6 months.

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
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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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American Academy
of Pediatrics



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NICHQ

National Initiative for Children's Healthcare Quality

McNeil
Consumer & Specialty Pharmaceuticals

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

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____





ICANS Informed Consent

I, _____ (*parent's name*), am the parent or legal guardian of

(*minor client's name*).

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency **Willow Sage Services** _____ (*name of provider/agency/organization*) to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.

I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.

I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

EXPIRATION

This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.

I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward’s information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	Relationship to Client	Date
Full Legal Signature of Parent or Legal Guardian – <i>Required if Client is under 16 years of age, but only after signed by client.</i>	Relationship to Client	Date
Full Legal Signature of Witness (Agency Employee)	Initiating Agency Name	Date

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Name (Last, First) Child's Date of Birth: (mm/dd/yy) / /

Subscriber ID Authorization #

Clinician Name (Last, First) Today's Date: (mm/dd/yy) / /

Clinician ID/Tax ID Clinician Phone () - State MRef

Visit #: 1 or 2 3 to 5 Other

Relationship to child: Mother Father Stepparent Other Relative Child/Self Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
1. Destroyed property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Was unhappy or sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Behavior caused school problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Had temper outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Worrying prevented him/her from doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Felt worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Had trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Changed moods quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Used alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Was restless, trouble staying seated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Engaged in repetitious behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Used drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Worried about most everything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Needed constant attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much have your child's problems caused:	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
15. Interruption of personal time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Disruption of family routines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Any family member to suffer mental or physical problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Less attention paid to any family member?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Disruption or upset of relationships within the family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Disruption or upset of your family's social activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How many days in the past week was your child's usual routine interrupted by their problems?				<input type="text"/> Days

- Answer the following only if this is your first time completing this questionnaire for this child.**
22. In general, would you say your child's health is: Excellent Very Good Good Fair Poor
23. In the past 6 months, how many times did your child visit a medical doctor? None 1 2-3 4-5 6+
24. In past month, how many days were you unable to work because of your child's problems? Days
(answer only if employed)
25. In the past month, how many days were you able to work but had to cut back on how much you got done because of your child's problems? Days
(answer only if employed)

