Patient Package Behavioral Health

Fellsway Pediatrics
Boston Children's
Primary Care Alliance

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Primary Care Alliance

548 Lebanon Street, Melrose, MA 02176
781-665-4364 | *fax* 781-662-2284 | fellswaypediatrics.com

Fellsway
Pediatrics

To Whom It May Concern:

You are receiving this packet after requesting an evaluation from your provider with concerns of anxiety and or depression.

Before an appointment can be made in our office, please take the time to read through this packet and fill out all of the attached paperwork. If you would like to fill out this paperwork on-line, please email me your child's name and date of birth at my email listed below. Once I receive your email I will register you for the questionnaires online and forward you the invitation to complete them. Once the paperwork is returned to our office an appointment can then be scheduled.

If you have any questions about the information provided to you in this packet please contact the office for assistance.

Please feel free to email or call Brittney with any non-medical questions regarding this information.

Brittney.Ferguson@fellswaypedi.com

Sincerely,
—Fellsway Pediatrics

Fellsway Pediatrics

Behavioral Health Treatment Protocol

To Whom It May Concern,

You or your child has requested an evaluation for a Behavioral Health concern. It is very important that you read this protocol thoroughly. Once you review this, please sign and date the bottom stating that you agree to follow the protocol in its entirety. Once evaluated in the office, it is possible we will be prescribing medication for treatment. It is required for you to begin or continue working with a Therapist, Psychiatrist or Psychologist. Our office will work together with your therapist, by managing your medication. Being treated within the office, there are certain guidelines you must adhere to too make sure you get the best level of care.

First, as mentioned above, you will be required to work with a CBT therapist, psychiatrist, psychologist or social worker. Our office will be working hand and hand with your therapist to make sure you receive the best care in treating your diagnosis. We are here to help you in this journey. In this packet will be a list of recommendations for therapists you can contact. You can call your insurance company to see who they recommend, and if those options are insufficient please contact us. We will work together in helping make this process easier. We understand that finding a therapist maybe challenging. The sooner you start looking, the easier and faster it will be. **To completely manage your behavioral health needs, it is required that a therapist is initiated within 2 months.** There are complex issues that require a team approach. Without all of the team in place, it is very difficult to manage these difficult conditions. **Failing to meet with a therapist in a timely fashion, may require the physician to discontinue medications until a therapist is found.**

Second, you must agree and comply with the office follow up care plan in order for us to manage your medication properly. Meaning, after your initial visit and if a prescription is filled you will be scheduled for a follow up in one month. Within the one month you will be receiving weekly phone calls to check on any adverse reaction, additional or worsening symptoms, etc. Once you come in for your first scheduled follow up appointment you will be re-evaluated. If the medication stays the same you will be scheduled for a follow up in two more months. At that point the phone calls will become bi-weekly until the next appointment. At the third follow up appointment you will be reevaluated again and our follow up calls will lengthen to monthly calls. At any point and time you can call us to discuss the medication or diagnosis. **If the medication needs to be adjusted the above process will start over again.** These protocols are set in place for the best treatment of the patient.

The office goal in treating behavioral health patients in our office along with your therapist is to have a positive outcome within twelve months. After twelve months, if we still feel like you require medication we may refer your case to a specialist who can provide care with a deeper knowledge of cognitive behavior issues.

Sincerely,

Fellsway Pediatrics

Please sign below if you agree to follow the above care plan for the treatment and management of behavioral health:

Patient Name: _____ DOB: _____

Parent/Patient Signature (if over 18 years old): _____ Date: _____

Fellsway Pediatrics

Release of Information

In order to manage your child's care we need a signed release from their current therapist. Please fill out all of the information below. **Do not return this form unless each section is filled out entirely.**

E***ach patient must have a separate release form! Please make copies as needed***

1- Patient information: If patient is over 18 years or older the form must be completed with their information.

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

_____

2- Information to be released from:

I, _____ do hereby authorize Fellsway Pediatrics to receive my personal health
(Patient name if over 18)
Information from the following persons at the location listed below:

Doctor/Facility name: _____

Office Number: _____ Fax Number: _____

Address: _____

_____

3- Information to be released to:

Doctor/Facility name: ____Fellsway Pediatrics_____

Office Number: _____781-665-4364_____ Fax Number: ____781-662-2284_____

Address: 548 Lebanon Street, Melrose, MA 02176

1- Privileged Information to be Released:

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

◯ YES ◯ NO Sexually Transmitted Infection (STI) results and/ or notes.

◯ YES ◯ NO Alcohol and drug abuse records

◯ YES ◯ NO Details of Mental Health diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Mental Health specialist

◯ YES ◯ NO Details of domestic violence

◯ YES ◯ NO Details of sexual assault counseling

I understand that:

- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Fellsway Pediatrics.
- This authorization will expire in 6 months unless otherwise specified
- Medical records can take 7-10 business days to be mailed or ready for pick-up

_____ _____

Guardian/ Patient Signature if over 18 or form will be invalid ***Date***

_____ _____

Guardian/ Patient printed name ***Relationship to Patient***

Parent Form – Part 1

Patient Name: _____ DOB: _____

Parent Name: _____ Relationship: _____ Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	**PN**
2. My child gets headaches when he/she am at school.	O	O	O	**SH**
3. My child doesn't like to be with people he/she does't know well.	O	O	O	**SC**
4. My child gets scared if he/she sleeps away from home.	O	O	O	**SP**
5. My child worries about other people liking him/her.	O	O	O	**GD**
6. When my child gets frightened, he/she fells like passing out.	O	O	O	**PN**
7. My child is nervous.	O	O	O	**GD**
8. My child follows me wherever I go.	O	O	O	**SP**
9. People tell me that my child looks nervous.	O	O	O	**PN**
10. My child feels nervous with people he/she doesn't know well.	O	O	O	**SC**
11. My child gets stomachaches at school.	O	O	O	**SH**
12. When my child gets frightened, he/she feels like he/she is going crazy.	O	O	O	**PN**
13. My child worries about sleeping alone.	O	O	O	**SP**
14. My child worries about being as good as other kids.	O	O	O	**GD**
15. When my child gets frightened, he/she feels like things are not real.	O	O	O	**PN**
16. My child has nightmares about something bad happening to his/her parents.	O	O	O	**SP**
17. My child worries about going to school.	O	O	O	**SH**
18. When my child gets frightened, his/her heart beats fast.	O	O	O	**PN**
19. He/she child gets shaky.	O	O	O	**PN**
20. My child has nightmares about something bad happening to him/her.	O	O	O	**SP**

Parent Form – Part 2

Patient Name: _____ DOB: _____

Parent Name: _____ Relationship: _____ Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.	O	O	O	**GD**
22. When my child gets frightened, he/she sweats a lot.	O	O	O	**PN**
23. My child is a worrier.	O	O	O	**GD**
24. My child gets really frightened for no reason at all.	O	O	O	**PN**
25. My child is afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for my child to talk with people he/she doesn't know well.	O	O	O	**SC**
27. When my child gets frightened, he/she feels like he/she is choking.	O	O	O	**PN**
28. People tell me that my child worries too much.	O	O	O	**GD**
29. My child doesn't like to be away from his/her family.	O	O	O	**SP**
30. My child is afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. My child worries that something bad might happen to his/her parents.	O	O	O	**SP**
32. My child feels shy with people he/she doesn't know well.	O	O	O	**SC**
33. My child worries about what is going to happen in the future.	O	O	O	**GD**
34. When my child gets frightened, he/she feels like throwing up.	O	O	O	**PN**
35. My child worries about how well he/she does things.	O	O	O	**GD**
36. My child is scared to go to school.	O	O	O	**SH**
37. My child worries about things that have already happened.	O	O	O	**GD**
38. When my child gets frightened, he/she feels dizzy.	O	O	O	**PN**
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	**SC**
41. My child is shy.	O	O	O	**SC**

Child (Patient) Form – Part 1 *** Only for patients 13 and older***

Patient Name: _____ DOB: _____ Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	**PN**
2. I get headaches when I am at school.	O	O	O	**SH**
3. I don't like to be with people I don't know well.	O	O	O	**SC**
4. I get scared if I sleep away from home.	O	O	O	**SP**
5. I worry about other people liking me.	O	O	O	**GD**
6. When I get frightened, I feel like passing out.	O	O	O	**PN**
7. I am nervous.	O	O	O	**GD**
8. I follow my mother or father wherever they go.	O	O	O	**SP**
9. People tell me that I look nervous.	O	O	O	**PN**
10. I feel nervous with people I don't know well.	O	O	O	**SC**
11. I get stomachaches at school.	O	O	O	**SH**
12. When I get frightened, I feel like I am going crazy.	O	O	O	**PN**
13. I worry about sleeping alone.	O	O	O	**SP**
14. I worry about being as good as other kids.	O	O	O	**GD**
15. When I get frightened, I feel like things are not real.	O	O	O	**PN**
16. I have nightmares about something bad happening to my parents.	O	O	O	**SP**
17. I worry about going to school.	O	O	O	**SH**
18. When I get frightened, my heart beats fast.	O	O	O	**PN**
19. I get shaky.	O	O	O	**PN**
20. I have nightmares about something bad happening to me.	O	O	O	**SP**

Child (Patient) Form – Part 2 *** Only for patients 13 and older***

Patient Name: _____ DOB: _____ Date: _____

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.	O	O	O	**GD**
22. When I get frightened, I sweat a lot.	O	O	O	**PN**
23. I am a worrier.	O	O	O	**GD**
24. I get really frightened for no reason at all.	O	O	O	**PN**
25. I am afraid to be alone in the house.	O	O	O	**SP**
26. It is hard for me to talk with people I don't know well.	O	O	O	**SC**
27. When I get frightened, I feel like I am choking.	O	O	O	**PN**
28. People tell me that I worry too much.	O	O	O	**GD**
29. I don't like to be away from my family.	O	O	O	**SP**
30. I am afraid of having anxiety (or panic) attacks.	O	O	O	**PN**
31. I worry that something bad might happen to my parents.	O	O	O	**SP**
32. I feel shy with people I don't know well.	O	O	O	**SC**
33. I worry about what is going to happen in the future.	O	O	O	**GD**
34. When I get frightened, I feel like throwing up.	O	O	O	**PN**
35. I worry about how well I do things.	O	O	O	**GD**
36. I am scared to go to school.	O	O	O	**SH**
37. I worry about things that have already happened.	O	O	O	**GD**
38. When I get frightened, I feel dizzy.	O	O	O	**PN**
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport).	O	O	O	**SC**
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.	O	O	O	**SC**
41. I am shy.	O	O	O	**SC**

Child (Patient) Form – Part 3 *** Only for patients 13 and older***

Patient Name: _____ DOB: _____ Date: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

Child (Patient) Form – Part 1 *** Only for patients 12 and younger***

Patient Name: _____ DOB: _____ Date: _____

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situation	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him/ her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total Score: _____

Fellsway Pediatrics

Psychology/Behavioral/Therapy

Psychological Care Associates
Locations: in Arlington, Woburn, Stoneham and Chelmsford
Phone: 781-646-0500 (New patients ext 126)
Insurances: This practice accepts most insurance **except** Mass Health, Network Health, Neighborhood Health, Boston Medical Health Net, Children's Medical Security Plan and Fallon Health Care.
Ages: All
Services Provided: Multiple services
www.psychologicalcareassociates.org/

Children's Neuropsychological Services, LLC
Location: 26 Chestnut Street, Suite E, Andover, MA 01810 (Offices in Arlington and Exeter NH)
Phone: 978-749-2700
Insurances: BCBS only
Ages: 4-24 years
Services Provided: Neuropsychological Evaluations
www.childrensneuropsych.com

NESCA- Neuropsychology & Education Services for Children & Adolescents
Location: 55 Chapel Street, 2nd Floor, Newton, MA 02458
Phone: 617-658-9800
Insurances: Some BCBS plans (Must call to see if yours is accepted)
Ages: 18 months- 25 years old
Services Provided: Neuropsychological Evaluations
http://www.nesca-newton.com/

North Shore Psychology and Behavioral Medicine Assoc.
Locations: 6 Essex Center Drive, Suite 107, Peabody, MA 01960 (Locations in Winthrop)
Phone: 978-532-7588
Insurances: BCBS, Tufts, HPHC, Aetna, UHC, Tricare
Ages: 6 & older
Services Provided: Psychology
www.nspbm.com

DCS Mental Health
Locations: 151 Mystic Ave, Suite 6 Medford MA 02155 (Locations in Natick & Raynham)
Phone: 781-396-1199
Insurances: BCBS, Tufts, HPHC, Fallon, Mass Health, Network Health, Neighborhood Health, Boston Medical Center
Ages: 5 & older
Services Provided: Psychiatry, Medication management, Family Therapy, Group Therapy
www.dcsmentalhealth.com

Psychotherapy Associates of North Reading
Locations: 58 Concord Street, North Reading, MA 01864 & 5 Market Sq., Suite 102, Amesbury, MA 01913
Phone: 978-664-2566
Insurances: All insurances **except** Cigna
Ages: All Ages
Services Provided: Multiple Services
http://www.panr.net/

North Shore Clinicans Group, LLC
Locations: 1R Newbury Street, Suite 205, Peabody, MA 01960
Phone: 978-535-1608
Insurance: BCBS, Fallon, HPHC, TriCare, Tufts, UHC, Unicare, Mass Health, Network Health, Neighborhood Health, Boston Medical Center

Ages: All ages
Services Provided: Individual, Family and Couples Counseling
www.nscliniciansgroup.com/

Riverway Counseling Assoc.
Location: 10 High Street, Suite 10, Medford MA 02155
Phone: 781-395-1560
Insurance: Most insurances including Mass Health
Ages: All ages
Services Provided: Multiple Services
www.riverwaycounseling.net/

Mark Deyab, LICSW
Location: 1 West Foster St, 3rd Floor, Melrose MA 02176
Phone: 781-799-3949
Insurance: Aetna, Fallon, BCBS, Cigna, HPHC, Neighborhood Health, Network Health, Tricare, Tufts, UHC
Ages: 7 & up
Services Provided: Multiple services
www.markdeyablicsw.com/

Michael Luba, MSW
Location: 6 Eastman Place, Melrose, MA 02176
Phone: 781-665-0607
Insurance: No Insurances – Self pay only
Ages: 5 & Up
Services Provided: Multiple Services

Ellen Holtzman, Psy.D.
Location: 7 Lincoln Street, Suite 304, Wakefield, MA 01880
Phone: 781-245-1422
Insurance: All insurances **except** Mass Health, Network Health, Neighborhood Health, Boston Medical and GIC
Ages: 9-12 for anxiety only – ages 12 & ^ for any issues
Services Provided: Multiple services

Grandview Psychology Assoc.
Location: 1 West Foster Street, Melrose, MA 02176
Phone: 617-306-9095
Insurance: Aetna, Fallon, BCBS, Cigna, HPHC, Tufts
Ages: All ages
Services Provided: Multiple services
www.grandviewpsych.com

Arbor Counseling Services
Location: Multiple locations including; Woburn, Lowell, Brookline, Allston, Franklin **&many more locations**
Phone: Please check website for location phone numbers
Insurance: Most insurances including Mass Health
Ages: All ages
Services Provided: Multiple services
www.arbourhealth.com/

Elliot Community Human Services
Location: Multiple locations including; Malden, Melrose, Reading, Saugus, Woburn **&many more locations**
Phone: Please check website for location phone numbers
Insurance: Most insurances including Mass Health
Ages: All ages
Services Provided: Multiple services
www.eliotchs.org/