Clinical Center for Adults with Neuro-Developmental Disorders - CCAND

NEW PATIENT FORM – DATE COMPLETED: ___ / ___ / _____

NAME: _____

DATE OF BIRTH: _____ **WEIGHT:** _____ **(POUNDS)**

HEIGHT: _____ **(FEET)** _____ **(INCHES)**

ADDRESS: _____

_____

PARENT / GUARDIAN NAME: _____

EMAIL: _____

CELL PHONE: _____ **HOME PHONE:** _____

PRIMARY REASON FOR VISIT: _____

_____

_____

LIST OF DIAGNOSES: _____

_____

_____

_____

_____

CARE TEAM

REFERRING PROVIDER: _____

PHONE: _____

ADDRESS: _____

_____

CURRENT NEUROLOGIST: _____

PHONE: _____

ADDRESS: _____

_____

Clinical **C**enter for **A**dults with **N**euro-Developmental **D**isorders - **CCAND**

NEW PATIENT FORM – DATE COMPLETED: ___ / ___ / _____

PRIMARY CARE PROVIDER: _____

PHONE: _____

ADDRESS: _____

_____

PSYCHIATRIST / THERAPIST: _____

PHONE: _____

ADDRESS: _____

_____

OTHER PROVIDER (? SPECIALTY): _____

PHONE: _____

ADDRESS: _____

_____

OTHER PROVIDER (? SPECIALTY): _____

PHONE: _____

ADDRESS: _____

_____

PLEASE LIST ANY SUPPORT SERVICES THAT YOU CURRENTLY HAVE IN PLACE:

_____

_____

_____

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NEW PATIENT FORM – DATE COMPLETED: ___ / ___ / _____

PLEASE SELECT WHICH OF THE FOLLOWING YOU CURRENTLY HAVE IN PLACE:

- ❑ **GUARDIANSHIP**
- ❑ **POWER OF ATTORNEY**
- ❑ **LIVING WILL / ADVANCED DIRECTIVE**
- ❑ **OTHER:** _____

PREFERRED LOCAL PHARMACY
PHONE: _____
ADDRESS: _____
_____
MEDICATIONS THAT YOU GET FROM HERE: _____
_____
_____

SPECIALTY PHARMACY
PHONE: _____
ADDRESS: _____
_____
MEDICATIONS THAT YOU GET FROM HERE: _____
_____
_____

ALLERGIES: ____ **NO KNOWN DRUG ALLERGIES**

_____
_____
_____

Clinical **C**enter for **A**dults with **N**euro-Developmental **D**isorders - **CCAND**

NEW PATIENT FORM – DATE COMPLETED: ___ / ___ / _____

CURRENT MEDICATIONS:

NAME OF MEDICATION	STRENGTH	HOW IS IT TAKEN?	IS BRAND NAME REQUIRED?

Clinical **C**enter for **A**dults with **N**euro-Developmental **D**isorders - **CCAND**

NEW PATIENT FORM – DATE COMPLETED: ___ / ___ / _____

PLEASE SEND THE FOLLOWING TO CCAND PRIOR TO YOUR VISIT IF AVAILABLE: ***IF YOU DO NOT HAVE THIS INFORMATION, PLEASE REQUEST FROM PREVIOUS PROVIDERS.***

- **LAST NOTE FROM REFERRING PROVIDER / NEUROLOGIST / PRIMARY CARE PROVIDER**
- **MOST RECENT LAB REPORTS - INCLUDING MEDICATION LEVELS**
- **MOST RECENT EEG REPORT**
- **MOST RECENT MRI (BRAIN, ABDOMEN, CHEST, ETC)**
- **GENETICS TESTING REPORTS (IF THEY HAVE BEEN DONE)**
- **COPY OF POWER OF ATTORNEY**
- **COPY OF GUARDIANSHIP DOCUMENTS**
- **COPY OF LIVING WILL / ADVANCED DIRECTIVE**
- **ANYTHING ELSE THAT YOU THINK WILL BE HELPFUL DURING YOUR VISIT**

FAX REPORTS TO 410 – 448 - 6382

PLEASE SEND THIS COMPLETED FORM AND SUPPORTING DOCUMENTS TO THE CCAND CLINIC ASAP FOR REVIEW.

THERE ARE 4 CONVENIENT WAYS TO RETURN THIS FORM:

- **FAX TO 410-328-0697**
- **SEND THROUGH My Portfolio**
- **EMAIL TO dbridges@som.umaryland.edu**
- **MAIL TO: CCAND CLINIC – ATTN- DANA BRIDGES**
  2200 KERNAN DRIVE, AMBULATORY PRACTICE B
  ROOM G374
  BALTIMORE, MD 21207

CALL WITH QUESTIONS @ 410-448-2485.

THANK YOU IN ADVANCE.

LOOKING FORWARD TO MEETING YOU.

CCAND CLINIC TEAM