

**ST. JOSEPH'S REGIONAL MEDICAL CENTER  
THE PEDIATRIC FEEDING AND SWALLOWING CENTER  
AT  
ST. JOSEPH'S CHILDREN'S HOSPITAL  
100 HOSPITAL PLAZA  
PATERSON, NJ 07503  
(973) 754-4300 FAX (973) 754-4330  
www.feedingcenter.org**

Dear Parent,

Welcome to the Center for Pediatric Feeding and Swallowing Center. Our team looks forward to greeting and evaluating your child. An intake form (complete and mail or fax to Helen ASAP) and two surveys are attached. Multidisciplinary team is here to provide your family with the best available services in the world today but from the onset you as the parent/caretaker need to be a part of the team and take ownership of insurance referrals/authorizations.

**It is necessary for you to obtain complete information and authorizations from your insurance company that will allow your child to receive services here in the Center. You are responsible for getting your referrals/authorizations and keeping track of them for your initial visit as well as future visits. During your appointment your child will have a team evaluation by the physician, speech pathologist, behavior analyst, physical or occupational therapist.**

Steps for obtaining an evaluation:

- 1) **You and not any staff member at the Center** will need to check with your insurance company to see if a referral should be written for Dr. Peggy Eicher. Dr. Eicher is a specialist in this field and may require a referral for the initial consult/and follow up visits. Dr. Escher's Tax ID #22-2810004 you may need this # to verify with insurance that the doctor is in-network and under your plan.
- 2) If you are required to have a referral for Dr. Eicher you may **also** need one for St. Joseph's Regional Medical Center Tax ID# 22-1487602 who will be billing the therapy portions of the evaluation. You will need to check with your insurance company to see if a referral or a pre-certification is required by your carrier for the Physical Therapy **EVALUATION** (CPT #97001), Occupational Therapy **EVALUATION** (CPT #97003), Speech **EVALUATION** (CPT #92610). You can inquire about this through the 1-800 number on the back of your card.
- 3) Also for any follow up visits that involve the Speech Therapist CPT #92626 will be billed to your insurance. You will need to know how many visits you are allowed in a year and if it needs to be pre-authorized. The Speech Pathologist will obtain any authorizations needed.

If you require any additional assistance during this initial visit indicate that need directly on the intake form.

**Please bring a meal that your child is typically eating as well as their utensils. During the assessment we might recommend a different sized spoon to help your child eat better. If that is recommended we will need you to purchase that spoon at the cost of \$1.00. The evaluation will last approximately 1-1 ½ hrs.**

Por favor este informado que si Usted no habla Ingles fluente, es su responsabilidad de traer un interprete para sus citas de evaluacion y las sesiones del tratamiento. La evaluacion y el tratamiento no se la va' a negar a su hijo/hija pero usted tiene que estar informado que la sesion sera' limitada y que la barrera del idioma existe.

Your appointment is scheduled for \_\_\_\_\_ @ \_\_\_\_\_. Attached you will find two surveys that we would appreciate you completing and bringing with you the day of your evaluation. Please begin this survey 14 days prior to your visit.

**Your co-payment is due on the day of service.** You will not be cleared for services at the Center if the co-payment is not paid. If this occurs your child's appointment for that day will be rescheduled. We accept cash, checks and credit cards. If you do not have your co-payment with you another appointment with be scheduled for your child.

Sincerely,

Peggy Eicher, MD- Medical Director

William J. Roche MS CCC BRS- S – Clinical Director

**St. Joseph's Children's Hospital**  
**The Pediatric Center for Feeding & Swallowing**  
**Phone: (973) 754-4300 Fax: (973) 754-4330**  
**www.feedingcenter.org**

PFC# \_\_\_\_\_

Name: \_\_\_\_\_ M F  
 DOB: \_\_\_\_\_ SS# \_\_\_\_\_  
 Legal Guardians: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_  
 (W) \_\_\_\_\_  
 Fax/e-mail: \_\_\_\_\_  
 Home Address: \_\_\_\_\_

Referral: \_\_\_\_\_  
 Pediatrician: \_\_\_\_\_  
 Peds address: \_\_\_\_\_  
 Peds phone: \_\_\_\_\_

Describe feeding concerns: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_  
 Diagnoses: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

**Developmental Issues:** (circle what applies)  
 cognitive motor speech

**Services:** (circle what applies)  
 OT PT ST ED ABA Other

**Allergies to foods or medicines:** \_\_\_\_\_  
**Immunizations up to date? Y\_\_ N \_\_If not why** \_\_\_\_\_

<b>Respiratory Issues:</b> (check ALL that apply & explain below)			
<input type="checkbox"/> Congestion	<input type="checkbox"/> Coughing in a.m	<input type="checkbox"/> Coughing after meals	<input type="checkbox"/> Frequent illnesses
<input type="checkbox"/> Apnea	<input type="checkbox"/> Snoring	<input type="checkbox"/> Mouth Breathing	<input type="checkbox"/> Pneumonia's
<input type="checkbox"/> Noisy Breathing	<input type="checkbox"/> Irreg. Breathing	<input type="checkbox"/> Grunting	<input type="checkbox"/> Cyanosis (blueness)
<input type="checkbox"/> Trach	<input type="checkbox"/> Vent	<input type="checkbox"/> Valve	
<b>Gastrointestinal Issues:</b> (check ALL that apply & explain below)			
<input type="checkbox"/> Gags	<input type="checkbox"/> Limits intake	<input type="checkbox"/> Goes less than daily	<input type="checkbox"/> Chest/abdominal pain
<input type="checkbox"/> Wet burps	<input type="checkbox"/> Vomiting after meals	<input type="checkbox"/> Poor wt gain	<input type="checkbox"/> Self induced vomiting
<input type="checkbox"/> Arching after meals		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Pale/lethargic after meals			
<input type="checkbox"/> Tube feeding G, J, GJ, NG	Formula/rate/quantity/delivery method _____		
While having a bowel movement: <input type="checkbox"/> Cries/grunts <input type="checkbox"/> Hard/ball-like <input type="checkbox"/> Strains/gets red in face			
<b>Oral-motor Issues:</b> (check ALL that apply & explain below)			
<input type="checkbox"/> Poor tongue control	<input type="checkbox"/> Choking	<input type="checkbox"/> Gulping air	
<input type="checkbox"/> Drooling	<input type="checkbox"/> Oral defensive	<input type="checkbox"/> Food from nose	
<input type="checkbox"/> Swallowing problem	<input type="checkbox"/> Chewing problem	<input type="checkbox"/> Dental problems	
<b>Mealtime Behaviors:</b> (check ALL that apply & explain below)			
<input type="checkbox"/> Food refusal	<input type="checkbox"/> Aggression	<input type="checkbox"/> Food selective types: _____	
<input type="checkbox"/> Grazes	<input type="checkbox"/> Tantrums	<input type="checkbox"/> Prolonged meals (_____ min.)	
<input type="checkbox"/> Spitting	<input type="checkbox"/> Pockets food in cheeks		
<input type="checkbox"/> Choking			
Other _____			

**Insurance Info: Primary**  
 Co. Name: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 SS #: \_\_\_\_\_  
 ID#: \_\_\_\_\_  
 Grp #: \_\_\_\_\_  
 Case Manager: \_\_\_\_\_  
 CM Phone #: \_\_\_\_\_

**Secondary** (enter if different from primary)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**This form must be filled out and returned prior to your visit. Please attach a copy of your insurance card.**  
 If your insurance plan requires prior authorization/approval for this visit, it is **YOUR** responsibility to obtain this, before your evaluation appointment. You will be financially responsible for this visit, if it is not approved. See attached letter for instructions on authorization/approvals. **Thank you.**