The Milton J. Dance, Jr.
Head & Neck Center
Johns Hopkins Voice Center at GBMC
6569 North Charles Street
Physicians Pavilion West, Suite 401
Baltimore Maryland 21204
443-849-2087 fax 443-849-2649

# Pediatric Patient Packet

Welcome to The Milton J. Dance, Jr. Head & Neck Center at GBMC New Patient Appointment Forms page.

**Thank you for accessing our new patient forms online.**

These forms are also mailed to new patients. They are posted on line for your convenience. The attached packet has all the forms needed for your initial appointment with us. Please bring these completed forms with you to your appointment along with the following:

1. Insurance cards and driver's license (or MD state identification card).
2. Exact co-pay amount, which may require you to call your insurance company before your appointment. Co-pay amounts may vary according to the type of service given. When calling your insurance company please specify the appointment as, the type of evaluation, treatment, therapy or procedure (as highlighted above).
   Referrals, if required by your insurance carrier. Please obtain this from your primary care physician and/or insurance company. Primary care physicians are not required to provide us with referrals on or after the day of your appointment. You will be asked to sign a liability form accepting responsibility for any charges incurred if no referral is obtained.

Please complete the attached forms and bring them with you to your scheduled appointment. To schedule an appointment or, regarding questions concerning your upcoming appointment, please call 443-849-2087.

We hope to make this a 'Very Good' experience for you and strive to meet the needs of our patients. If you have any questions or concerns please feel free to call me at 443-849-8451.

Sincerely,

Barbara P. Messing, M.A., CCC-SLP, BCS-S
Administrative-Clinical Director

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***PLEASE COMPLETE FORM ENTIRELY***

**PATIENT REGISTRATION FORM**

NAME______________________________________________
*Last* *First* *M.I.*

PHONE ( )____________________CELL ( )____________________

EMAIL______________________________

SS#__________-__________-________

RACE Black White Hispanic Other:____________________

RELIGION____________________

---

NEXT OF KIN:

NAME:____________________

ADDRESS:____________________

CITY/ST:____________________ZIP________

PHONE____________________WORK__________

RELATIONSHIP TO PATIENT:____________________

PERSON TO NOTIFY:

NAME:____________________

ADDRESS:____________________

CITY/ST____________________ZIP________

PHONE____________________WORK__________

RELATIONSHIP TO PATIENT:____________________

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I certify that the demographic information provided above is current and accurate to the best of my knowledge.

I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to **MILTON J. DANCE, JR. HEAD AND NECK CENTER at GBMC** for services rendered to me.

Signature of Patient and/or Financially Responsible Party____________________Date____________________

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# MEDICATIONS SHEET

## MEDICATION LIST

It is important that you fill this out **COMPLETELY.** If need be, find out from your doctors, the exact dose of any medicines you are taking. This list should include prescription medicines, over-the-counter medicines, vitamins, and supplements from any source. For example, the list should include aspirin, the contraceptive birth control pill, vitamins, minerals, herbal remedies, sports supplements, and any supplements (powders, tablets, drinks, etc.) from an alternative medicine source or health shop.

Name of Local Pharmacy______________________________________Name of Mail Order Pharmacy__________________________
City__________________________________________________City_______________________________________________
Phone________________________Fax__________________________Phone________________________Fax___________________

| Medication Name | Dose (how much) | Frequency (how often) |
|---|---|---|
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| DRUG ALLERGIES (please list any medications you have had a reaction to) | | | |
|---|---|---|---|
| **Name of Medication** | **Reaction** | **Name of Medication** | **Reaction** |
| | | | |
| | | | |

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**PERMISSIONS / ACKNOWLEDGEMENTS – Page 1 of 4**

***USE AND DISCLOSURE OF HEALTH INFORMATION*** – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information (including information related to psychiatry, drug abuse, alcoholism, or HIV testing) for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information pertaining to this hospitalization to other health care providers for continuing care and treatment.

***PRE-CERTIFICATION REQUIREMENTS*** – If my insurance company or third-party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification. EXCEPTION: Medicare

***ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS*** – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

***MEDICARE/MEDICAID PATIENT CERTIFICATION(for Medicare/Medicaid patients only)*** – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

722-779 (6/10)

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**I understand that I have been instructed to leave all valuables at home, give such valuables to a friends or family member, or if that is not possible, to deposit such valuables with the GBMC Security Office. I understand that I am responsible for safekeeping such items as eyeglasses, dentures, or hearing aides, or any of my property while it is in my possession or under my control. I release the hospital from any responsibility for loss of any item not deposited with the Security Office.**

Has the patient received the Notice of Privacy Practices?
_____ Yes
_____ No

Reason no NOPP given:
_____Newborn
_____Patient Unable to Accept

***PATIENT FINANCIAL POLICY***

We are committed to providing you with quality and affordable health care. You are receiving this information because under Maryland law, GBMC must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance or your insurance does not cover your medically necessary hospital care and you have a low income.

**Hospital Financial Assistance Policy:**

- GBMC provides emergency and urgent care to all patients regardless of ability to pay.
- GBMC offers several programs to assist patients who are experiencing difficulty paying their hospital bills.
- GBMC complies with Maryland's legal requirement to provide financial assistance based on income level and family size.
- GBMC Patient Representatives are available to assist you with the application process **(see contact information on page 6)**, or you may access an application by going to http://www.gbmc.org/ (go to the Patient & Visitor Tab and then click Financial Support).

**Patient Rights:**

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.

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- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance **(see contact information on page 6).**
- You may be eligible for Maryland Medical Assistance a program funded jointly by the state and federal governments **(see contact information on page 6).**

**<u>Patients' Obligations:</u>**

- For those patients with the ability to pay their hospital bill, it is the obligation of the patient to pay the hospital in a timely manner.
- GBMC makes every effort to see that patient accounts are properly billed. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under GBMC's financial assistance policy, or if you cannot afford to pay the bill in full you should contact the Patient Financial Services department promptly to discuss this matter **(see contact information on page 6).**
- If you fail to meet your financial obligations for services received, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If you r financial position changes, you have an obligation to promptly contact Patient Financial Services to provide update/corrected information **(see contact information on page 6).**

**<u>Physician Services:</u>**

**Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. Depending upon your treatment plan, you may receive separate bills for all services rendered including but not limited to, GBMC, the physician treating you, Charles Emergency Physicians, Advanced Radiology, Physicians Anesthesia Associates, Radiation Oncology Healthcare, Greater Baltimore Pathology Associates, Pediatric Physicians, etc.**

**<u>Insurance:</u>** We participate in most insurance plans, including Medicare. Please remember to always bring your insurance card with you when you come for a visit.

- **Co-payments and deductibles** – All co-payments and deductibles must be paid at the time of services. This arrangement may be part of your contractual agreement with your insurance company. Please assist us by being prepared to submit your co-payment for each visit.
- **Referrals/Authorizations/Pre-certifications** – You may be responsible for obtaining precertification, submitting a referral and/or authorization prior to being seen, if required by your insurance carrier (except Medicare). Please obtain your pre-certification, referral and/or authorization from your primary care physician and submit at the time of service.
- You may also be responsible for tracking your referrals (number of remaining visits and expiration date). Please obtain additional or new referrals as necessary.

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- **Non-covered services** – Some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Please contact your insurance company with any questions you may have regarding coverage. If your insurance does not cover the services it does not necessarily mean that you do not need the services. Your physician will explain why he or she thinks that you can benefit from a service or procedure. If you elect to receive the non-covered services, you will be financially responsible.
- **Medicare patients** – If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal Medicare's decision.
- **Claims submission** – We will submit your claim(s) and assist in any way we reasonably can to ensure claim payment. Your insurance company may require you to supply certain information directly. The balance of your claim is your responsibility regardless of your insurance company payment and GBMC is not party to that contract.
- **Coverage changes** – Please notify us before your next visit of any coverage changes so that we may assist you in maximizing your benefits.
- **Acceptable forms of payment** – We accept cash, personal checks, money orders, Visa, MasterCard, Discovery, American Express and we offer payment plans.

**Contact Information**

- **GBMC Patient Representatives are available Monday through Friday, from 8:00 am to – 6:00 pm at (443) 849-2450, option 1, or at 1-800-626-7766, option 1.**
- Our representatives can assist you with applying for Maryland Medical Assistance or you may also obtain information about or apply for Maryland Medical Assistance by contacting your local Department of Social Services by phone at 1-800-332-6347; TTY: 1-800-925-4434; or on the Internet at www.dhr.state.md.us .

I have read and understand in its entirety the information provided in this document and agree to follow its guidelines.

______________________________________ ____________________________

**Signature of Patient or Responsible Party** **Date**

______________________________________

**Relationship to Patient**
**(if signed by person other than the patient)**

722-779 (6/10)

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## GBMC Managed Care Liability Form

I am (or the minor or other individual for whom I am responsible is) enrolled in ___________________ (HMO/PPO/POS) managed care health plan.

I understand that, if appropriate, GBMC will bill my health plan for services to be rendered. However, I also understand that there are instances where GBMC is authorized to bill me directly:

- **When I receive services that are not covered under my health plan.**

  If my health plan decides that the services I receive are not covered under my benefit policy, I understand that I will be responsible for payment of these services rendered.

- **When I receive services at GBMC which are covered by my health plan only when performed by a specific provider.**

  My health plan may require me to obtain certain services from a specific provider or facility. I understand that I have been informed that GBMC is not one of those providers for which payment will be made, yet I choose to go ahead and request the service from GBMC anyway due to convenience, preference or any other reason, I will be responsible for payment of these services rendered.

**I understand that I am responsible for any deductibles, coinsurance or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), and "out-of-network" preferred and indemnity benefits and for payment of services not covered under my policy. I understand that I can receive treatment regardless of my ability to pay. If I choose NOT to obtain these services at GBMC, I understand I am accepting responsibility for this decision. My signature below indicates that I understand the above, and if any of the above apply, I agree to pay all fees that result from receiving these services.**

______________________________________ ______________________

**Patient/Responsible Party Signature** **Date**

______________________________________

**Patient/Responsible Party Name - Printed**
722-524 (11/05)

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## Authorization for Release of Protected Health Information to a Spokesperson

*As stated in the Greater Baltimore Medical Center's (GBMC) Notice of Privacy Practices, "we may release health information about you to a family member, other relative, or any other person identified by you who is involved in your care with your permission "*

**By signing this authorization, I allow GBMC to the tell the spokesperson(s) named below the following information:**

- My x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plan either in person or by telephone.

**By signing this authorization, I understand the following:**

- This applies to services being rendered to me by the GBMC physician practice named below ______________________________________________.
- This authorization is voluntary.
- Once this information is released to the spokesperson(s), the released information may no longer be protected by the federal privacy regulations.
- The spokesperson(s), medical power of attorney, health care agent or other individual allowed by law will be the only person(s) who may obtain specific information about me.
- My spokesperson(s) does not have decision-making abilities unless he/she is able to do that as set forth in the law.
- This authorization will expire one year from the date signed below unless a specific expiration event or condition is named here:________________________________.
- I may withdraw this authorization at any time by notifying the GBMC Privacy Officer in writing. If I do withdraw the authorization, it will not have any effect on actions taken by GBMC prior to receiving the written request.
- My treatment will not be affected by me choosing to sign or not to sign this document.
- I may refuse to sign this authorization.

**YOU WILL RECEIVE A COPY OF THIS FORM ONCE IT IS COMPLETED**

Patient Name: ______________________________________________DOB:__________

**Spokesperson Information:** **PRINT CLEARLY**

Name: ____________________________Relationship to Patient:_______________ Phone:______________

Name: ____________________________Relationship to Patient:_______________ Phone:______________

Name: ____________________________Relationship to Patient:_______________ Phone:______________

______________________________________ ______________________________
Signature of Patient or Patient's Representative Date

______________________________________ ______________________________
Printed name of Patient’s Representative Relationship to Patient

601-C69 2/06

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**GBMC HEALTHCARE**
**CLINICAL POLICY AND PROCEDURE**
**APPENDIX C**
**OUTPATIENT PAIN ASSESSMENT TOOL**

| **GBMC HEALTHCARE**<br>6701 North Charles Street<br>Baltimore, Maryland 21204<br>OUTPATIENT PAIN ASSESSMENT TOOL | **DATE:**______________________________ |
|---|---|

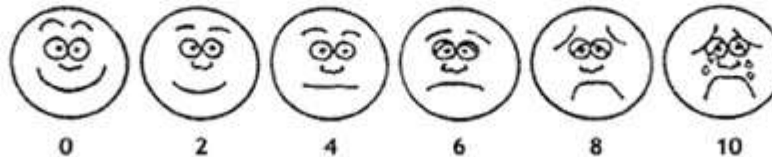
1. Are you having pain? (circle) NO YES (if yes, complete questions 2-11)

2. Where is your pain?________________________________________

3. Circle all the words that can be associated with your pain:

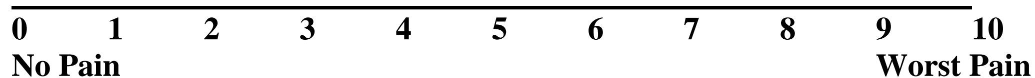
| | | | | |
|---|---|---|---|---|
| constant | aching sharp | penetrating | tearful | gnawing |
| intermittent | throbbing | tender | nagging | moaning |
| dull | shooting | burning | numb | grimace |
| even at rest | exhausting | stabbing | miserable | unbearable |

3. Rate your pain by circling on one of the scales below:




**Faces Scale**

**Numbers Scale**



**0 1 2 3 4 5 6 7 8 9 10**
**No Pain** **Worst Pain**

5. What makes your pain better? ____________________________________

6. What makes your pain worse?____________________________________

7. Does your pain interfere with daily activities? (circle) YES NO

8. What treatments or medicine do you use to relieve your pain?
(include prescriptions and over the counter drugs)

________________________________________________________

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9. How effective has your treatment/medication been?
   - ☐ Always effective ☐ Often effective ☐ Often not effective
   - ☐ Never effective

10. Have you experienced any side effects (sleepiness, nausea, constipation) from medicines?
    - ☐ No ☐ Yes, explain______________________________

11. What level of pain is tolerable and acceptable to you? ______________________________

12. Please check the following:

_________I have been educated about pain and its treatment

_________I have received the GBMC brochure regarding my rights for effective pain management.

_________I refuse education and treatment at this time.

_________I refuse to fill out this form

**Patient Signature** __________________________

---

(Physician/Nurse to complete)

13. Treatment Plan:

________ Referred to Physician ___________________________M.D.

________ RX given ______________________________

**Physician/Nurse Signature**__________________________

## Follow up assessment:

Telephone Contact**:** **Date:** ______________________________
☐ See post-operative/procedure phone call form.

Comments:______________________________________________

**Visit Contact**: Date:_________________________________

Physician/Nurse_________________________________________

# Speech-Language Developmental History

**CHILD'S INFORMATION**
Name: ________________________________________________ Birthdate: _______________________

**FAMILY INFORMATION**
Parents/Legal Guardian Name(s): ____________________________________________________________
Mother's occupation: _______________________________________ Work phone: __________________
Father's occupation: _______________________________________ Work phone: __________________

Brothers/Sisters (list names and ages):
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Does anyone else live in the home? (List name and relationship to child)
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Is there any history of speech, language, hearing, or learning problems in your family? ☐ Yes ☐ No
If yes, describe problem and relationship of family member to child.

**AREAS OF CONCERN** *(Check all that apply.)*

| | | |
|---|---|---|
| ☐Behavioral and/or emotional | ☐Difficulty answering questions | ☐Listening |
| ☐Immature language | ☐Difficulty understanding directions | ☐Feeding/Swallowing |
| ☐Speech difficult to understand | ☐Reading | ☐Tongue Thrust |
| ☐Slow motor development | ☐Stuttering | ☐Other _____________ |

Why are you requesting this evaluation? Please provide examples of your concerns. (use back as needed)

**PREVIOUS EVALUATIONS**
Has a physician, psychologist, speech pathologist, or other specialist evaluated your child in regards to these concerns? ☐ Yes ☐ No
If yes, please list name of examiner(s), area(s) of specialty, and date(s) of evaluation.

Was a diagnosis determined? ☐ Yes ☐ No
If yes, please explain:

**MEDICAL HISTORY**

Pregnancy and Birth

Was pregnancy and delivery normal? ☐ Yes ☐ No

If no, explain any complications:

Was your child: ☐ Full term? ☐ Premature? (How many weeks?) ______ Birth weight: __________

Baby's condition at birth (jaundice, breathing problems, etc.) ____________________________________

________________________________________________________________________________

Medical History (Please check past or present health problems)

| | | |
|---|---|---|
| ☐ allergies | ☐ asthma | ☐ pneumonia |
| ☐ ear infections | ☐ colds | ☐ high temperature or fever |
| ☐ injuries/accidents/falls | ☐ surgeries/hospitalizations | ☐ enlarged tonsils or adenoids |
| ☐ use of hands/legs | ☐ hearing | ☐ vision |
| ☐ seizures | ☐ serious injuries/accidents/falls | ☐ other serious illness |
| ☐ drooling | ☐ feeding or swallowing problems | |

Please explain any checked items above.

List any medications taken on a regular basis:

List medical treatments (i.e, tubes, inhalers, ear wax removal, feeding tubes):

List allergies:

**DEVELOPMENTAL HISTORY**

Motor Development (*List approximate ages.)*

Sat alone: ________________ Crawled: __________________ Walked alone: __________________

Fed self with a spoon: _____________ Toilet trained: __________________

Speech and Language Development *(List approximate ages.)*

Babbled: ______________Spoke first words (other than *mama* or *dada):* _________________________

Used two-word sentences: _________________Spoke in short sentences: ________________________

Does your child communicate primarily using: ☐ speech? ☐ gestures?

Languages other than English spoken in the home: ____________________________________________

Does you child speak this language? ☐ Yes ☐ No Understand this language? ☐ Yes ☐ No

Which language does the child prefer to speak? ________________________________________________

**SOCIAL DEVELOPMENT/BEHAVIOR**

What opportunities does your child have to play with children of his/her age?

Describe how your child interacts with others.

Does she/he play primarily: ☐ with other children? **Or** ☐ alone?

Does she/he enjoy *pretend play*? ☐ Yes ☐ No

Do you have concerns about your child's behavior? ☐ Yes ☐ No If yes, please explain:

**EDUCATIONAL HISTORY**

Schools/daycare programs attended:

Name: ______________________________ Address: _______________________ Grades: _____________

Name: ______________________________ Address: _______________________ Grades: _____________

Name: ______________________________ Address: _______________________ Grades: _____________

If child is in school, are there any concerns about academic performance (e.g., reading, writing, subject areas).

☐ Yes ☐ No If yes, please explain

List any special services that your child has received (e.g. Head Start, therapy, etc.):

Type of service: ____________________ Ages:___ Dates: __________School/agency:______________

Type of service: ____________________ Ages:___ Dates: __________School/agency:______________

Type of service: ____________________ Ages:___ Dates: __________School/agency:______________

**INTEREST INVENTORY**

What are your child's interests and favorite activities?

Does your child have any fears (e.g. such as stuffed animals, loud noises)?

Please provide any additional information that might be helpful.

Form Completed by: _______________________ Relationship to child: __________________________
Date: ________________

**FEEDING HISTORY**
(Complete this section only if child is referred for feeding or swallowing concerns).

**How does your child eat and drink?**

- ☐ All foods and liquids by mouth
- ☐ Some foods and liquids by mouth with supplemental tube feedings
- ☐ Tube feedings with foods and liquids for therapy and/or pleasure
- ☐ All foods and liquids by tube

**If your child receives tube feedings, please list method (nasal tube, stomach tube, etc.), formula, amounts (per feed), and feeding schedule.**
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**What food and liquid consistencies does your child eat? (Check all that apply)**

☐ Regular liquids
☐ Thickened liquids _______________
☐ Baby cereal
☐ Stage 1 baby foods (smooth)
☐ Stage 2 baby foods (semi-chunky)
☐ Stage 3 baby foods (chunky)
☐ Mashed/soft table foods
☐ Regular table foods
☐ Other ______________________________

**Describe your child's position while eating/drinking.** ____________________________

**Is your child breast-fed?**

☐ No, was never breast-fed

☐ No longer breast-fed

**Did your child have any difficulties with breastfeeding?**

☐ No
☐ Yes If yes, please describe ___________________

☐ Yes

**How often does your child breastfeed daily?** __________________________
**How long is each feeding?** ________________________________________
**Does your child have any difficulties with breastfeeding?**

☐ No
☐ Yes If yes, please describe___________________________

**Does your child use a bottle?**

☐ No, was never bottle-fed

☐ No longer uses a bottle

**When did your child start/stop bottle-feeding?** _________________________
**Did your child have any difficulties with bottle-feeding?**

☐ No
☐ Yes If yes, please describe____________________

☐ Yes

**At what age was bottle introduced?** _________________________________
**What type of bottle/nipple is used?** _________________________________
**How often does your child bottle-feed daily?** ___________________________
**How long is each feeding?** ________________________________________
**Does your child have any difficulties with bottle-feeding?**

☐ No
☐ Yes If yes, please describe____________________

**Does your child use a cup?**

☐ No

☐ Yes

**At what age was cup drinking introduced? ________________________________**
**Does your child use a special cup? _ ___________________________________**
**If you child is also breast-fed or bottle-fed, how often does your child use a cup? ______________________________________________________________**
**Does your child have any difficulties with cup drinking?**

- No
- Yes If yes, please describe _______________________

**Does you child eat solid (soft or chewable) foods?**

- No
- Yes

**At what age did your child first start to eat solid foods? ____________________**
**Does your child self-feed? If no, who typically feeds your child? ___________**
**How long does it take your child to finish a meal? _________________________**
**Did your child have any difficulty transitioning to solid foods?**

- No
- Yes If yes, please describe_______________________

**What difficulties is your child having with feeding/swallowing? Please describe:**

- Coughing
- Excessively Long Mealtimes (>30 Minutes)
- Nasal Regurgitation
- Gastric Esophageal Reflux Disease (GERD)
- Spitting Up/Vomiting After Meal
- Poor Weight Gain
- Drooling
- Picky Eater
- Nasal Congestion
- Gagging
- Crying and Fussing After Meals
- Other______________________________

**Have these problems been evaluated or treated? How and by whom?**

**Please list your child's typical feeding routine**.

| **Meal/Snack** | **Time of Day** | **Time to Complete** | **Typical foods or liquids consumed & amount** |
|---|---|---|---|
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**What are your child's favorite foods?**

**What foods will your child NOT eat?**

**What foods are easiest for your child to eat?**

**What foods are difficult for your child to eat? Describe the difficulty**.