

Fellsway Pediatrics

548 Lebanon Street, Melrose, MA 02176

Tel: 781-665-4364 • **Fax:** 781-662-2284

www.fellswaypediatrics.com

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 e-mail me your child's name and date of birth at my e-mail listed below. Once I receive your e-mail 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 e-mail or call Brittney with any non-medical questions regarding this information.

E-mail: Brittney.Ferguson@fellswaypedi.com

Phone:

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.**

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

Parent Form – Part 2

Patient Name: _____ **DOB:** _____

Parent Name: _____ **Relationship:** _____ **Date:** _____

	0	1	2	
	Not True or Hardly Ever True	Somewhat True or Sometimes True	Very True or Often True	
21. My child worries about things working out for him/her.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
22. When my child gets frightened, he/she sweats a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
23. My child is a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
24. My child gets really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
25. My child is afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
26. It is hard for my child to talk with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
27. When my child gets frightened, he/she feels like he/she is choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
28. People tell me that my child worries too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
29. My child doesn't like to be away from his/her family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
30. My child is afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
31. My child worries that something bad might happen to his/her parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
32. My child feels shy with people he/she doesn't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
33. My child worries about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
34. When my child gets frightened, he/she feels like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
35. My child worries about how well he/she does things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
36. My child is scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
37. My child worries about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
38. When my child gets frightened, he/she feels dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
41. My child is shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
2. I get headaches when I am at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
3. I don't like to be with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
4. I get scared if I sleep away from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
5. I worry about other people liking me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
6. When I get frightened, I feel like passing out.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
7. I am nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
8. I follow my mother or father wherever they go.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
9. People tell me that I look nervous.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
10. I feel nervous with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
11. I get stomachaches at school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
12. When I get frightened, I feel like I am going crazy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
13. I worry about sleeping alone.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
14. I worry about being as good as other kids.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
15. When I get frightened, I feel like things are not real.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
16. I have nightmares about something bad happening to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
17. I worry about going to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
18. When I get frightened, my heart beats fast.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
19. I get shaky.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
20. I have nightmares about something bad happening to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
22. When I get frightened, I sweat a lot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
23. I am a worrier.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
24. I get really frightened for no reason at all.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
25. I am afraid to be alone in the house.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
26. It is hard for me to talk with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
27. When I get frightened, I feel like I am choking.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
28. People tell me that I worry too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
29. I don't like to be away from my family.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
30. I am afraid of having anxiety (or panic) attacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
31. I worry that something bad might happen to my parents.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SP
32. I feel shy with people I don't know well.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
33. I worry about what is going to happen in the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
34. When I get frightened, I feel like throwing up.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	PN
35. I worry about how well I do things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
36. I am scared to go to school.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SH
37. I worry about things that have already happened.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	GD
38. When I get frightened, I feel dizzy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	SC
41. I am shy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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 fidgety 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 Clinicians 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/