Welcome to the Westchester Institute for Human Development (WIHD). The attached Registration Packet must be completed prior to the patient’s first appointment.

The following information is required to be completed:

**WIHD PAPERWORK**

- [ ] Registration Form
- [ ] ATP Initial Intake Form
- [ ] Consent for Care and Treatment
- [ ] Cancellation and Missed Appointment Agreement

**PLEASE COMPLETE AND MAIL/FAX/EMAIL THIS REGISTRATION PACKET AS SOON AS POSSIBLE TO:**

AT Program  
Westchester Institute for Human Development  
Cedarwood Hall – Room 422  
20 Plaza West (GPS)  
Valhalla, New York 10595  
Ph: 914-493-1317  
Fax: 914-493-3964  
atp@wihd.org

If you have questions feel free to contact us.
### PATIENT INFORMATION

**Patient's Last Name**

**First**

**Middle**

- [ ] New Registration
- [ ] Registration Update

**Preferred Language**

**Social Security #**

N/A

**Race/Ethnicity (for gov't reporting)**

- [ ] White
- [ ] Black/African Am
- [ ] Asian
- [ ] Hispanic/Latino
- [ ] Other

**Birth Date**

/ / 

**Age**


**Sex**


**Residential Agency & House (if Applicable)**

**Phone No.**

( )

**Fax (if available)**

( )

**Street Address (Home or Residential Agency)**

City

State

ZIP Code

**Agency Contact Name (if Applicable)**

**Email Address**

**Pharmacy Name & Address**

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**Does he/she have a Health Care Proxy or other form of Advance Directive (MOLST, Living Will, DNR)? (If over 18 years old)**

- [ ] Yes
- [ ] No

*If you would like more information please speak with your provider.*

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**Primary Care Provider**

**Phone No.**

**Dental Care Provider**

**Phone No.**

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### FAMILY/GUARDIAN INFORMATION

**Parent/Guardian/Foster Parent Name (1)**

**Relationship to Patient**

**Home Phone No.**

( )

**Work Phone No.**

( )

**Street Address**

City

State

ZIP Code

**Email Address**

**Do you have Guardianship? (If over 18 yr. old)**

- [ ] Yes
- [ ] No

*If Yes, Does WIHD have a copy of papers (required)?* Yes / No

**Parent/Guardian/Foster Parent Name (2)**

**Relationship to Patient**

**Home Phone No.**

( )

**Work Phone No.**

( )

**Street Address**

City

State

ZIP Code

**Email Address**

**Do you have Guardianship? (If over 18 years old)**

- [ ] Yes
- [ ] No

*If Yes, Does WIHD have a copy (required)?* Yes / No

**Mother's Maiden Name (if Applicable)**

**Preferred Contact Instructions**

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### INSURANCE INFORMATION

**Medicaid No.**

N/A

**Medicare No.**

N/A

**Private Insurance Co. (1)**

N/A

**Policy No.**

N/A

**Name of Insured**

N/A

**Relationship to Patient**

N/A

**Private Insurance Co. (2)**

N/A

**Policy No.**

N/A

**Name of Insured**

N/A

**Relationship to Patient**

N/A
ASSISTIVE TECHNOLOGY EVALUATION TEAM

INITIAL INTAKE FORM

Please complete and return to:

Assistive Technology Program
Westchester Institute for Human Development
20 Plaza West - 422 Cedarwood Hall
Valhalla, NY 10595-1689
Email: atp@wihd.org
Tel# 914-493-1317
Fax# 914-493-3964

Date:______________________________

1) Name of Applicant:____________________________________DOB______________________
   Address:_________________________________________________________________________
   Phone:_________________________________  Email:__________________________________
   Is applicant in school?  [  ] Yes  [  ] No
   If yes, school & grade:
   Is applicant employed?  [  ] Yes  [  ] No    If yes, employer:_______________________________

2) Parent/Guardian/Spouse (if applicable):_____________________________________________
   Address:_________________________________________________________________________
   Home Phone:__________________Cell Phone:__________________E-mail:_________________

3) Primary Contact (for appointments etc.):___________________________________________

4) Physician:_______________________________________________________________________
   Address:________________________________________________________________________

5) Reason for Referral:_______________________________________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________

6) Medical Diagnosis and/or Functional Concerns:_____________________________________
   _______________________________________________________________________________
   _______________________________________________________________________________

7) Please identify any health concerns that are pertinent to the evaluation.
[ ] hearing loss  [ ] seizures  [ ] vision problems  [ ] recurring health problems

[ ] medications  [ ] other: ___________________________________________________________

Explanation of checked items: _______________________________________________________
________________________________________________________________________________
________________________________________________________________________________

8) Current AT equipment being utilized in home, school and/or work environment. (communication
device, switches, expanded keyboards, software, walkers, wheelchairs etc.)
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

9) Does the individual have any activity interests and preferences (e.g., games) or sensory preferences
(colors, lights, sounds): ____________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

10) List specific concerns or questions you want addressed in this evaluation: ______________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

11) Is there any other information that you feel we should know: __________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Please fill out APPLICABLE PORTIONS ONLY of the remaining pages. Thank you.
FUNCTIONAL OVERVIEW

1) Has the individual ever received speech/language therapy? __________________________
How does the individual generally make himself/herself understood (e.g., speech, gestures, graphic cues, object cues, vocalizing)? __________________________

2) Does the individual presently receive speech/language therapy? _________________
Please describe the time period, frequency of service, and major goals in therapy:


SLP’s name & phone: __________________________

3) How do you communicate with the individual?
Verbal alone: __________________________
Verbal with visual cues: __________________________

4) What kinds of information does the individual communicate spontaneously?


5) Please identify specific means of communicating:

   [ ] facial expressions   [ ] gestures/informal signs   [ ] behavior
   [ ] sign language      [ ] sounds               [ ] alphabet board
   [ ] words              [ ] non-electronic communication

6) How does the individual gain your attention when you are not paying attention to him/her?


7) How does the individual ask questions for directions, information and personal needs?


8) How does the individual communicate choices or indicate preferences?
________________________________________________________________________
________________________________________________________________________

9) Does this client have a recognizable way to indicate yes/no? ______________________
If yes, please describe: ______________________________________________________
________________________________________________________________________
________________________________________________________________________

10) Please describe major educational setting(s) and major emphasis in program.
________________________________________________________________________
________________________________________________________________________

11) Cognitive Level: __________________________________________________________
Reading Level: ______________________________________________________________
Writing Skills: [ ] no ability [ ] legible handwriting [ ] keyboarding skills
Motor Abilities: [ ] ambulatory [ ] functional hand use [ ] functional head use
[ ] volitional controlled movement of body part (explain):
________________________________________________________________________
________________________________________________________________________

12) Does this individual presently receive OT? ________________________________
Please describe the time period, frequency of service, and major goals in therapy:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
OT’s name & phone: __________________________________________________________

13) Does the individual presently receive PT? ________________________________
Please describe the time period, frequency of services, and major goals in therapy:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
PT’s name & phone: __________________________________________________________

*Please forward any pertinent PT, OT and/or Speech Reports along with any current
IFSP/IEP or vocational reports.
1. I hereby authorize ____________________________ to participate in an Assistive Technology Evaluation and/or Training at the Assistive Technology Program at WIHD.

2. I acknowledge that no guarantees or assurances are made to me concerning the implementation of recommendations resulting from this evaluation by third parties.

3. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

**Patient/Relative/Guardian or Personal Representative**

______________________________  ________________________________
Signature of Parent/Guardian/Personal Representative  Print Name of Parent/Guardian/ Personal Representative

______________________________  ________________________________
Date  Description of Personal Representative’s Authority

**Interpreter (if required)**

______________________________  ________________________________
Signature  Print Name
We, at Westchester Institute for Human Development (WIHD), understand that sometimes you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please notify us as soon as possible. Missed or late appointments disrupt schedules that can impact you and other patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or email to you is made/attempted 1 business day prior to your scheduled appointment. However, it is your responsibility to arrive for your appointment on time.

**PLEASE REVIEW THE FOLLOWING POLICY**

1. We ask that you please cancel your appointment with at least 24 hours’ notice. This will enable us to accommodate other patients who are requesting similar time slots.

2. If you are more than 15 minutes late it is possible we may not be able to accommodate you. If you will be late please call in advance to make sure you can still be seen for the remainder of your appointment.

3. All late cancellations and no shows will be documented in your medical record.

4. Three or more late cancellations or no shows in a 3 month time frame may result in terminating services.

5. If there is a one-month lapse in treatment for services requiring ongoing consecutive sessions, without discussing with the clinician in advance, treatment may be terminated.

6. Please be aware that if your case is closed you may be placed on a waiting list and the same clinician or time slot cannot be guaranteed.

7. We will make every attempt to contact you after late cancellations and no shows. These attempts to contact you will be documented in your medical record.

8. If your services are terminated due to missed appointments we will attempt to assist you by recommending alternative providers.

I have read and understand WIHD’s Cancellation and Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify WIHD appropriately if I have difficulty fulfilling my scheduled appointments.

____________________________  ____________________________
Signature of Patient/Guardian  Date

____________________________  ____________________________
Printed Name  Relationship to Patient (if applicable)
DIRECTIONS TO WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD)

ASSISTIVE TECHNOLOGY DEPARTMENT – 914-493-1317
4TH FLOOR, ROOM 422

GPS
20 Hospital Oval West
Valhalla, NY

FROM THE BRONX AND SOUTH:
Bronx River Parkway North to Sprain Brook Parkway North. Exit at Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE NORTH:
Taconic Parkway South to Medical Center/Route 100 exit (just past the New State Police Headquarters). Turn right at top of exit ramp onto Route 100 South. Turn right at light, passing over parkway. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE WEST:
New York State Thruway South across Tappan Zee Bridge staying to the right as you go through tolls to Exit 8A (87 South). Follow signs for Saw Mill River Parkway North. Exit at Eastview, and turn right. Follow road through business park, remaining on Route 100C (bear left) as road forks. At second light, make a left into the Westchester Medical Center campus and follow road to stop sign at end. Turn left, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

FROM THE EAST:
Cross Westchester Expressway (287) Westbound to Exit 3 (Sprain Parkway). Bear left after exiting to Northbound Sprain. Take Sprain Parkway north to Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/ WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.