AMHERST PEDIATRIC ASSOC., P.C.
25 HOPKINS ROAD
WILLIAMSVILLE, NEW YORK 14221-4641
(716)-632-8050

Dear Teacher, CSE Chair, or Principal:

The parents of one of your students, _____, date of birth ____/____/_____, are seeking to have their child evaluated for a health concern. As part of our evaluation process, we ask that both the child's parents and teacher complete a set of behavioral rating scales. This information is important for the diagnosis and treatment of your student.

Your time and cooperation in this matter is appreciated. Attached, please find a release of information form that the parents have completed, and a set of teacher rating scales and questionnaires. Generally, the teacher who spends the most time with the child should complete the teacher rating scales. If the child is in middle or high school and has multiple teachers, it is useful for us to obtain a separate set of rating scales from each of the core subject teachers (ELA, Math, Science, Social Studies), and to have representation from teachers at different times of the day in order to gauge the efficacy of medication interventions and their rate of metabolism as it relates to symptom presentation. Please do not compare rating scales with other teachers, as the diversity of responses and symptom presentation provides invaluable information.

Please fill out the forms as completely as possible. Some of the questions may seem redundant; this is necessary to ensure that we obtain accurate diagnostic information.

We ask that you, _____ (school district), complete these forms as soon as possible, so that our provider is able to review the information prior to the patient's visit. The forms should be faxed to us directly at 716-632-2297, or mailed to Amherst Pediatrics, 25 Hopkins Road, Williamsville, NY 14221.

In addition, we request that you also forward any CSE evaluations, IEP or 504 Plans, or recent reports that may indicate the student's level of functioning.

Thank you for your assistance and cooperation in the completion of these forms. If you have any questions regarding the materials, or would like additional information regarding services provided, please do not hesitate to contact us at 716-632-8050.

I,_____ parent of _____,

date of birth _____/_____/_____, authorize

school district_____ and

specific school_____

to share information, including the Vanderbilt questionnaire and the records identified above, with Amherst Pediatrics. This information may be shared in person, by phone, by fax, or by mail. This information is for the purpose of assessing, diagnosing and treating my child.

I understand that I do not have to sign a release form; it is completely voluntary. I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing. Amherst Pediatrics will notify the school the child attends, should I withdraw my consent allowing for the exchange of information.

Date ____/____/_____

_____

Signature of Parent/Guardian

_____

Witness Signature (Amherst Pediatric Staff)