Intake Application

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Infant & Toddler Connection of Loudoun

Child’s Name: AAYAM RIJAL Birth Date: 04/17/2024 Sex at Birth: MALE Race/Ethnicity: ASIAN

Home Address: 21765 TOTTENHAM HALE CT, STERLING, VA 20166

(Street) (City) (State) (Zip)

Parent’s/Guardian’s Name: RUSHA BHATTARAI

Birth Date: 09/05/1988 Relationship to Child: MOTHER

Social Security #:618-85-2537 Phone: 5718882159

Email: RUSHABHATTARAI@GMAIL.COM Occupation: NURSE

Where Employed: NINOVA FAIROAK Work Phone:

Parent’s/Guardian’s Name: RATNA RIJAL Birth Date: 01/28/1989 Relationship to Child: FATHER Social Security #: 053-33-9165 Phone:5715283238 Email: RIJALRATNA20@GMAIL.COM Occupation: IT(SOFTWARE)

Where Employed: FREDDIE MAC Work Phone:

# Income/Insurance Information

Taxable Income: 202846 Insurance Company CIGNA

From row 15 of IRS 1040

Number of Dependents:2 Address:

Subscriber Name: ID#: U82939289 04 Group#: 3340013

# Children Living at Home

Name Birth Date Name Birth Date

1: AARAV RIJAL 04/24/2020 4:

2: AAYAM RIJAL 04/17/2024 5:

3: 6:

Others living with your family

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# Medical Care Information

What was your child’s full name at birth? AAYAM RIJAL Delivery: INOVA LOUDOUN HOSPITAL

(Name of Hospital) (Hospital’s Address)

Pediatrician’s Name/Office: KIMBETLY COLB /Pediatric Healthcare Address: 46440 Benedict Drive, Suite 207 Sterling, VA 20164

Office Phone: \_(703) 444-2100 Fax: (703) 444-0386

*List any specialists that have treated or evaluated your child:*

Physician’s Name Address (if known) Date Reason

*List times your child has been hospitalized:*

Hospital Physician Date Reason

*List any current or previous therapists:*

Name Address Date Reason

Has your child received a medical diagnosis? If yes, what is the diagnosis?

BLOOD TRANSMISSION

## Vision and Hearing:

List any vision or hearing medical diagnosis:

Did your baby pass the newborn hearing screening: *Yes*

Has your child’s hearing been formally tested: *Yes or No*

If yes, where was it completed and when?

Please describe any concerns regarding your child’s vision or hearing?

# Medical History Information

Pregnancy was:  Full or  Premature *(please check one)*

X

What was your child’s gestational age at birth: 07/05/2024 Describe any complications with pregnancy: DIABITIES.

Was the mother’s labor spontaneous or induced, if induced, how? N/A

Please describe any complications during labor?

INTERNAL BLEADING

Was your child delivered vaginally or caesarean? CAESARIAN Was the mother asleep or awake during delivery? AWAKE How did your baby present: head foot breech? *(Please check one)*

Describe any complications with delivery:

## Baby’s Condition at Birth:

Birth Weight: 1140 GRAMS

Was there any blueness or yellowness? If yes, please describe. Was baby put on oxygen? If yes, for how long? YES, 6 WEEKS

How old was your child when you first saw him/her? 0 DAYS How old was your child when you first fed him/her? 7 WEEKS Were there any problems with feeding, such as sucking, swallowing, choking, vomiting, etc?

Was your baby admitted to the NICU or any other inpatient medical facilities after birth?

*Yes*

If yes, please share the name of the inpatient medical facility, the length of stay, and describe the reason for the hospital stay?

PREMEATURITY, CPAP SUPPORT, FEEDING

# Family’s Routines, Concerns, Priorities, and Resources

Please describe your child's daily routine. What daily or family routines go well with your child?

FEEDING EVERY 2-4 HOURS DEPENDENS ON HE DESIRED, TAKE A BATH EVERY NEXT DAY. FEEDING 3 TIMES INFACARE/NEOSURE FORMULA AND REST PUMPED BREST MILK. SNUGGLE ONCE TIME PERMIT OR CRY.

What are some challenges that your child and family experiences during daily routines?

STRUGGLE TO FEED SOMETIMES

What does your child do well and/or what are his/her favorite activities?

SLEEP

What concerns you most about your child’s development?

PREMEATURITY TRACKING MILESTONE

What are your priorities for your child’s development while receiving early intervention services?

TO ENSURE HE GROWN WELL WITH OUT COMPLICATION DUE TO PREMEATURITY

Who else does your child spend time with on a regular basis outside of the immediate family?

Please write the name and location of the childcare if your child attends one. Or the full names of your child's primary caregiver if other than parents.

Please share any additional information that would be beneficial for the Early Intervention Team to know about your child’s development and/or medical history?

GRAND PARENT

Signature of Parent/Guardian Date 07/07/2024

*\* Thank you for completing the Intake Application. Our Early Intervention Team looks forward to providing services to your child and family.\**