ROCHESTER REGIONAL HEALTH

Developmental-Behavioral Pediatrics Program
Rochester General Hospital
Riedman Health Center
1455 East Ridge Rd Rochester, NY 14621
Phone (585) 922-4698 **Fax** (585) 922-5702

PHYSICIAN REFERRAL FORM

(To be completed by the child's physician)

Date:	*M*	*M*	/	*D*	*D*	/	*Y*	*Y*	*Y*	*Y*

Child's Name:										**Child's Age:**	
Date of Birth:	*M*	*M*	/	*D*	*D*	/	*Y*	*Y*	*Y*	*Y*	**Gender:**
Name(s) of Legal Guardian(s):											
Child's Address:	*STREET and APT NUMBER*										
	CITY						*STATE*			*ZIP CODE*	
Preferred Phone:	( )										

*****Remainder of this form must be completed and signed by child's physician*****			
Physician requesting consultation:		Phone:	( )
Name of person completing form:		Fax:	( )
Is child involved with?:	☐ Foster care ☐ Child Protective Services ☐ None of these		
If the child is not in the custody of the biological parent(s), please fax custody papers with this referral			
Preferred language:	☐ English ☐ Spanish ☐ Other:	Interpreter needed?	☐ Yes ☐ No

Child's developmental/behavioral diagnoses: ☐ Check if none
What primary concerns/questions would you like addressed?:

Please indicate any specific provider preference(s): ☐ Check if none					
Developmental Pediatrician		Psychologists			
☐	Jara Johnson, DO MPH	☐	Scott Anderson, PhD	☐	Marisa Malone, PhD
		☐	Kristine Kent, PhD	☐	Jessica Moore, PhD

Has the child previously been evaluated for these concerns?:	☐ Yes*	☐ No
*If yes, by whom and when? (please provide copies of reports)		

Child's Name:		**DOB:**	M	M	/	D	D	/	Y	Y	Y	Y

Please fax copies of all of the following with this referral:
☐ Growth charts (0-36 mos length, weight, head circumference AND 2-20 yo height, weight, BMI)
☐ Immunization records
☐ Last office visit detailing concerns for this referral
☐ Visit note from most recent well-child check with full physical exam (not health appraisal form)

Allergies (including reactions) ☐ Check if none
Medical diagnoses/problems ☐ Check if none

MEDICATIONS

Please list all medications child **currently takes**, especially those for inattention, anxiety, behavior, mood, or sleep. ☐ Check if none

Medication name	Reason prescribed	Dose/Frequency	Date started	Comments

Please list all medications child has **previously taken** for inattention, anxiety, behavior, mood, or sleep. ☐ Check if none

Medication name	Reason prescribed	Dose/Frequency	Dates taken	Reason discontinued

Signature of Physician **Date**

Please fax completed form to 585-922-5702. Thank you for your time in the care of this child.