**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: | | | | | ( ) | | | | | | | | | | | | | | | | | | | | | |
| **\*\*\*The remainder of the form must be completed and signed by the child’s physician\*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physician requesting consultation:** | | | | | | | | | | | | | | | | | | | | | Phone: | | | | ( ) | |
| Name of person completing form: | | | | | | | | | | | | | | | | | | | | | Fax: | | | | ( ) | |
| Is child involved with?: | | | | | | Foster careChild Protective ServicesNone 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 | | | | | |

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| **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 |  | Roger Yeager, PhD |
|  | |  | Jessica Moore, PhD |  | |

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

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| **Please fax copies of all of the following with this referral:** | | |
| Growth charts | Immunization records | Last office visit detailing concerns for this referral |

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

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| --- | --- | --- | --- | --- |
| **MEDICATIONS** | | | | |
| Please list all medications the child **currently takes**, especially those for inattention, anxiety, behavior, mood, or sleep. | | | | Check if none |
| Medication name | Reason prescribed | Dose/Frequency | Date started | Comments |
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|  |  |  |  |  |
| Please list all medications the child has **previously taken** for inattention, anxiety, behavior, mood, or sleep. | | | | Check if none |
| Medication name | Reason prescribed | Dose/Frequency | Dates taken | Reason discontinued |
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**Signature of Physician Date**

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