**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  |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |
| 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  |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |
|    |   |   |   |   |

**Signature of Physician Date**

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