



Center for Developmental Behavioral Pediatrics

Intake Request: Physician Referral (Part 1: Physician)

All patients need a physician referral before appointment can be scheduled

Date of Request ____/____/____

FOR OFFICE USE ONLY:

Date Received:

Appointment Date Scheduled:

PLEASE NOTE: The *Center for Developmental Behavioral Pediatrics specializes* in the assessment of developmental conditions that result in delayed milestones, inability to communicate effectively, learning problems, and poor or atypical social interactions. Evaluation and therapy are also provided. *For diagnosis or treatment of disorders that are primarily psychiatric or issues related to child abuse or custody please refer to mental health or psychiatric services. Area Psychiatric Services include Behavioral Health Associates at 423.899.0024 and Focus Psychiatric Services at 423.899.5081.*

Instructions for referrals: Our goal is to schedule patients as soon as both Physician and Parent Intake Forms are available to be clinically reviewed. Fax both forms together to expedite appointment scheduling. If your patient has urgent concerns, please call center to discuss with clinical staff. Appointment confirmation will be faxed to referring physician.

Patient Name _____
Last First Middle

Patient Date of Birth	Age	Sex	Race
Patient Street Address			
Patient City	State	Zip Code	County
Home Telephone (Include Area Code)			
Parents or Legal Guardian of Patient			
Work Telephone		Message Telephone	
Primary Care Physician			
PCP Telephone		PCP Fax	
Referring Physician (if different from PCP)			
Referring Physician Telephone		Referring Physician Fax	

Is this appointment a first time visit or a follow up visit?

First Time Visit _____ Follow-up Visit/ Last seen: _____

Siskin Children's Institute-T.C. Thompson Children's Hospital
Center for Developmental Behavioral Pediatrics

What is the PRIMARY concern for this referral?	
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Medication Consultation
<input type="checkbox"/> Autism Spectrum (Autism, Pervasive Developmental Disorder (PPD), Asperger's)	<input type="checkbox"/> Gross Motor or Fine Motor Difficulties
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Speech or Language Impairment
<input type="checkbox"/> Learning Impairment	<input type="checkbox"/> Disruptive Behavior < 6 years old
<input type="checkbox"/> Genetic Disorder:	<input type="checkbox"/> Other:
Any serious illnesses or major medical problems? If YES, please list problems:	Any vision problems?
	Any hearing problems?
Has this child previously received mental health diagnosis or treatment? If yes, please list:	Does this child take any medications on a regular basis? If yes, please list:
Is there anything else you would like us to know about the child?	

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Policy Holder and Date of Birth:	Policy Holder and Date of Birth:
Policy/Group #:	Policy/Group #:
ID #:	ID #:
Insurance Co. Phone #:	Insurance Co. Phone #:
Employer:	Employer:
Federal <input type="checkbox"/> No State <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes	Federal <input type="checkbox"/> No State <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes

Referring Physician Signature: _____

Print name: _____