siskin children's institute CENTER FOR DEVELOPMENTAL PEDIATRICS

A pediatric practice affiliated with The University of Tennessee College of Medicine Chattanooga, Department of Pediatrics and with Children's Hospital at Erlanger.

THE UNIVERSITY of TENNESSEE

children's

- USA -

PROVIDER REFERRAL FORM

Please Complete Entire Form

FAX to 1.888.599.0828 (Referrals Only)

PLEASE NOTE: We *DO NOT* accept referrals for the following ... Psychiatric Disorders, Issues Related to Custody Cases, or Parental Discord.

Date of Request:____/____/____

Patient Name _____

Last First Middle

Interpreter services needed: Yes ☐ No ☐ if yes, which language:

Patient Date of Birth:		Age:	Sex:
Patient Street Address:			
Patient City:	State:	Zip:	County:
Parents or Legal Guardian of Patient:			
Custody (please attach documentation if not in parental custody):			
Home Phone (Include Area Code):	Cell Phone:		
Work Phone:	E-mail:		
Primary Care Provider (PCP):			
PCP Phone:	PCP Fax:		
Referring Provider (if different from PCP):			
Referring Provider Phone:	Referring Provider Fax:		

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:

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NEW - In order to better serve your patients please complete all fields below- we will return the referral if left blank. Thank you

Behavioral Health/ABA Services *(18 Months – 12 Years)*	
Diagnosis: _____	**Reason for Referral** (Check All That Apply)
Assessment Tools Utilized to Inform Diagnosis (Check All that Apply)	☐ Challenging Behavior
☐ Autism Symptoms: ADOS-2/STAT/GARS-3/CARS	☐ Health and Safety Concerns
☐ Adaptive Skills: ABAS-2/Vineland-3	☐ Communication Concerns
☐ Cognitive Tests: _____	☐ Social/Emotional Concerns
☐ Genetic Tests	☐ Adaptive Living Skills
☐ Other: _____	☐ Caregiver Coaching/Support
	☐ Feeding Concerns
	☐ Other: _____

Please attach a copy of diagnostic evaluation with recent clinical updates supporting medical necessity of ABA Services.

This is frequently required for initial authorization.

Additional info, details, or comments.

Please Attach Current Progress Notes, Diagnostic Results, or Recent Therapeutic Evaluations/Recommendations associated with this referral.

Referring Provider Signature: _____ **Office Phone:** _____

Print name: _____ **Office Fax:** _____

Home Office: 1101 Carter Street, Chattanooga TN 37402 | MAIN: 423.490.7710 | MAIN FAX: 423.490.7750