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.

- CHATTANOOGA -

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:

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.

- CHATTANOOGA -

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.

Patient Name: _____

Last First Middle

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

REFERRAL FOR:

- ☐ Developmental Pediatrics
  - ☐ Evaluation only ☐ Evaluate and treat
- ☐ Applied Behavior Analysis (ABA) Therapy
- ☐ Occupational Therapy (OT)
- ☐ Speech Therapy (ST)
- ☐ Pediatric Feeding (PF)

REASON FOR REFERRAL:

Developmental Pediatrics (18 Months – 5 Years)

Date of last **Vision** test and results: _____

Date of last **Hearing** test and results: _____

Date of last **Lead** test and results: _____

Child is Currently Receiving

☐ ST ☐ OT ☐ PT ☐ None

Developmental Delay

☐ Speech Delay ☐ Cognitive Delay
☐ Motor Delay ☐ Self Care Delay

Autism Spectrum Disorder

☐ New Eval / Interdisciplinary Eval (MD, OT, & SLP when eligible)
☐ Previous Diagnosis

Social communication deficits? Yes ☐ No ☐
Repetitive-restricted behaviors? Yes ☐ No ☐
MCHAT Score: _____

Attention Deficit Hyperactivity Disorder

☐ ADHD – New Evaluation
☐ Previous Diagnosis

ADHD Medications current or tried in the past:

_____

Therapy Services (18 Months– 12 Years)

Diagnosis and Provider Signature ***Required for Order*:**

Diagnosis: _____

(For patients willing/able to maintain weekly visits)

☐ Speech Therapy

☐ Occupational Therapy

☐ Child is already receiving therapy or had an evaluation
(Please attach last evaluation since insurance may not cover if done within the last 6 months.)

Medical Diagnoses: _____

Medications: _____

Therapy Providers/Clinic: _____

Psychiatric Hospitalizations: _____

Behavioral Health Providers: _____

Please Attach Current Progress Notes and/or Recent Therapy Evaluations associated with this referral.

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

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.

- CHATTANOOGA -

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.

Patient Name: _____

Last First Middle

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: _____

Assessment Tools Utilized to Inform Diagnosis (Check All that Apply)

- ☐ Autism Symptoms: ADOS-2/STAT/GARS-3/CARS
- ☐ Adaptive Skills: ABAS-2/Vineland-3
- ☐ Cognitive Tests: _____
- ☐ Genetic Tests
- ☐ Other: _____

Reason for Referral (Check All That Apply)

- ☐ Challenging Behavior
- ☐ Health and Safety Concerns
- ☐ Communication Concerns
- ☐ Social/Emotional Concerns
- ☐ Adaptive Living Skills
- ☐ 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.

Pediatric Feeding Services (18 months – 12 Years)

Related Diagnosis: _____

Concerns for Safety of Swallow?

- ☐ Yes*
- ☐ No

*Please attach pertinent medical records.

Reason for Referral (Check All That Apply)

- ☐ Weight
- ☐ Limited Food Textures
- ☐ Limited Food Variety
- ☐ Taking Liquid Only
- ☐ Enteral Tube Dependent
- ☐ Challenging Behavior at Mealtime/Difficult Mealtime Routine
- ☐ Other: _____

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:** _____