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: |

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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**

**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– 5 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**

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THE UNIVERSITY of TENNESSEE UT | children's Hospital at Erlanger

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Last First Middle

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## *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 – 5 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:** _____