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:____/____/____

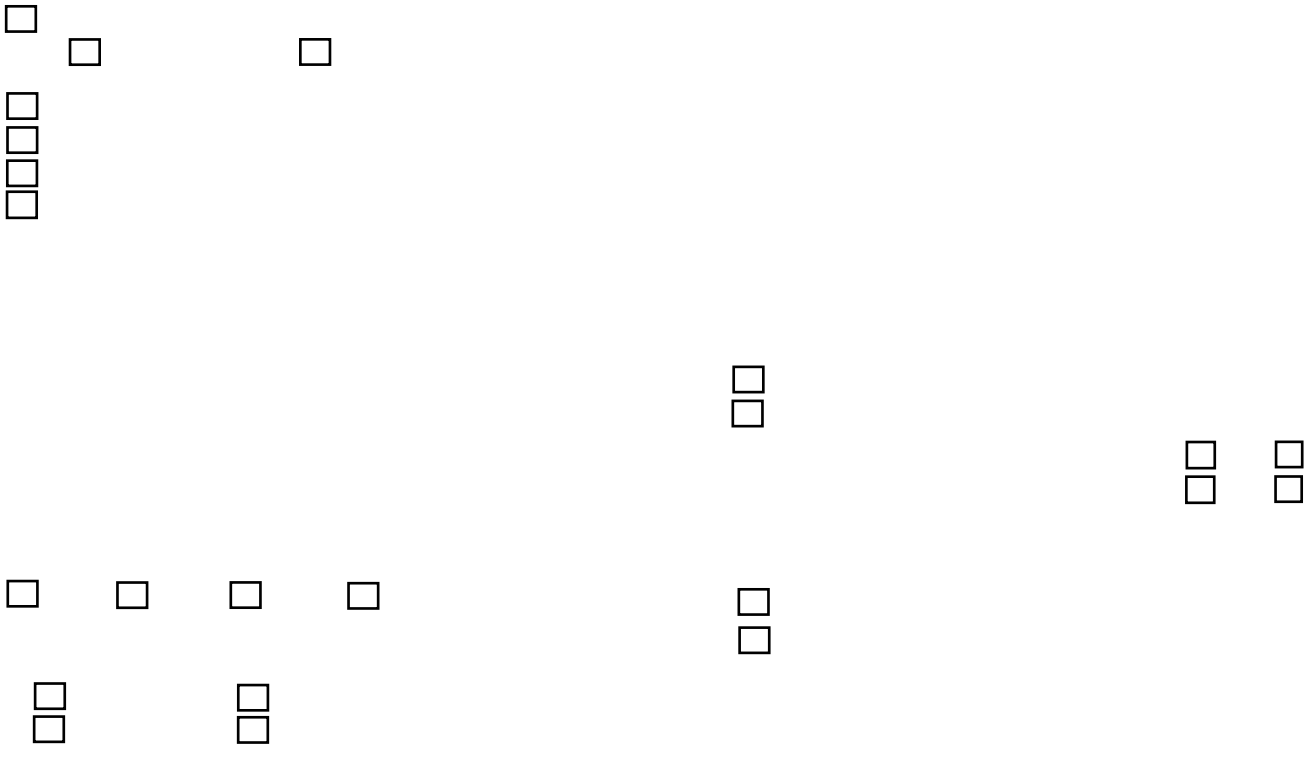
Patient Name _____

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

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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: _____

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:** _____