siskin CENTER FOR DEVELOPMENTAL PEDIATRICS
children's institute

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

Intake Request: Physician Referral

All patients need a physician referral

Please note: We *DO NOT* accept referrals for the following:
● Psychiatric disorders *not* listed below such as: conduct disorder, suicidal ideation, etc. ● Issues related to custody cases or parental discord

Date of Request: ___/___/___

Please complete entire form and fax to (423) 490-7750

Patient Name _____
Last First Middle

Patient Date of Birth:		Age:	Sex:
Patient Street Address:			
Patient City:	State:	Zip Code:	County:
Parents or Legal Guardian of Patient:			
Custody (please attach documentation if not in parental custody):			
Home Telephone (Include Area Code):	Cell phone:		
Work Telephone:	E-mail:		
Primary Care Provider:			
PCP Telephone:	PCP Fax:		
Referring Provider (if different from PCP):			
Referring Provider Telephone:	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 Center for Developmental Pediatrics specializes in the following conditions. Please mark the reason(s) for referral.

Developmental Pediatrics *Age 0-5 years*	***Therapy Services*** *Age 18 months – 12 years*	***Family Therapy***
Developmental Delay *(includes developmental concerns related to prematurity and genetic disorders)* ☐ Speech Delay ☐ Motor Delay ☐ Self Care Delay ☐ Vision Problems _____ ☐ Hearing Problems _____ Child is currently receiving: Speech ☐ OT ☐ PT ☐ Therapy clinic:_____	***Required for order*:** Diagnosis and provider signature below **Diagnosis:** _____ *(For patients willing/able to maintain weekly visits to SCDP)* ☐ ABA Therapy ☐ Speech Therapy ☐ Language/articulation ☐ Speech generating device ☐ Physical Therapy ☐ Occupational Therapy ☐ Feeding 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.)*	*** Please see separate form for referral to the Developmental Family Therapy Center.*
Autism Spectrum Disorder ☐ New Evaluation ☐ Evaluation only – PCP to manage ☐ Previous Diagnosis MCHAT Score: _____	**What is the DEVELOPMENTAL question/concern you want answered by this referral?** _____ _____ Medical diagnoses: _____ Medications: _____ Psychological diagnoses: _____ Psychiatric Hospitalizations: _____ Mental Health Providers: _____	
Attention Deficit Hyperactivity Disorder ☐ ADHD – Diagnosis only (PCP to manage medications) ☐ ADHD - SCDP to manage meds		

****** Please attach current progress note and/or recent therapy evaluations associated with this referral******

Referring Provider Signature: _____ **Office Phone**:_____
Print name: _____ **Office Fax**:_____
Name of Person Completing this form if other than Provider:_____