siskin children's institute
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center for DEVELOPMENTAL PEDIATRICS
An academic pediatric practice affiliated with the University of Tennessee College of Medicine Chattanooga

Referral From: (Check One)
- ☐ Physician/Therapist Referral
- ☐ SCDP Referral
- ☐ School Referral
- ☐ Self-Referral

Developmental Family Therapy Center
Counseling Referral Form

Please complete entire form and fax to (423) 490-7750 or mail to address below.

Identifying & Contact Information

Child's Name: _____ Date of Birth: _____/_____/_____

Current Age of Child: _____ Current Custody: _____

Parent/Guardian Name: _____ Parent/Guardian Name: _____

Address: _____ Home Phone: (_____)_____

_____ Cell Phone: (_____)_____

Counseling Referral Information

- As a Developmental Family Therapy Center, we utilize a systemic focus and offer individual, family, and group therapy services, along with parent trainings for families of children with special needs.
- For our counseling services, we accept referrals for families with children from Birth to 10.
- Our training and services focus on working with families and children with a variety of developmental conditions, including: Autism Spectrum Disorders, Anxiety Disorders, ADHD, Intellectual Delays, Developmental and Speech Delays, Chromosomal Developmental Impairments, Down Syndrome, & Sensory Integration Difficulties.
- We are not an emergency care center and do not accept referrals for psychiatric disorders beyond those developmental areas listed above, such as: Conduct Disorder, Suicidal Ideation, etc.

Referral For: (Check All Applicable Areas)

☐ Individual or Family Counseling Services

☐ Parent Empowerment Series (Parent Training Groups)

Child's Current Developmental Diagnoses: (Check All Applicable Areas)

☐ Autism Spectrum Disorder
☐ Anxiety Disorder
☐ ADHD
☐ Intellectual Delay
☐ Developmental Delay
☐ Speech Language Delay
☐ Cerebral Palsy and/or Motor Disabilities
☐ Chromosomal Developmental Impairments
☐ Down Syndrome
☐ Sensory Integration Difficulties

Reason for Referral:

_____

_____

Referral Source Information (*If not Self-Referral*)

Referring Provider: _____ Position: _____

Phone Number: _____ Fax Number: _____

Practice: _____ Signature: _____

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