THE UNIVERSITY OF KANSAS HEALTH SYSTEM

PHYSICIAN REFERRAL FORM

Developmental Pediatrics / 2000 Rainbow Blvd / MS 4003 / Kansas City, KS / 66160
PH 913-588-6300 / FAX 913-274-3546
https://www.kansashealthsystem.com/care/specialties/child-health-development

This referral form is to be completed by the child's pediatrician, primary care physician or psychiatrist only.

*Patients with mental health or behavior concerns ONLY (Depression, Anxiety, ODD, etc.) should be referred to The University of Kansas Health System, Pediatrics, Behavioral Pediatrics Section. Please call 913-588-6300 to schedule.

Date: _____ **Name of Medical Provider:** _____

Name of Practice:		
Address:		
City:	**State:**	**ZIP Code:**
Office Referral Contact Name:	**Phone:**	**Fax:**

Patient Information

Child's Name: _____ ___ _____
FIRST *MI* *LAST*

Date of Birth: _____ **Gender:** Male ☐ Female ☐ Other ☐

Primary Diagnosis: _____**ICD-10 code (*must complete*):** _____

Name of parent/guardian: _____ _____
FIRST *LAST*

Relationship to child:

- ☐ Biological parent
- ☐ Adoptive parent
- ☐ Agency Representative (Case Manager, Social Worker)
- ☐ Foster parent
- ☐ Other relative

Parent Home Phone: (_____)_____ **Parent Other Phone:** (_____)_____

Child home address:		
City:	**State:**	**ZIP Code:**

Primary language: ☐English ☐Spanish ☐Other: _____

Current Medications: _____

Has this patient received a formal hearing evaluation? Yes ☐ No ☐

Have you referred this patient to Infant and Toddler Services (ages 0-3)? Yes ☐ No ☐

Have you referred this patient to their local school district for special education services (ages 3 and older)? Yes ☐ No ☐

We highly recommend referrals to these agencies so that treatment may begin while patient is waiting for evaluation or treatment services from Developmental and Behavioral Pediatrics.

Insurance

Primary Insurance: _____ **Policy Holder Name:** _____

Policy Number: _____ **Group Number:** _____

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Previous and/or Current diagnoses

Does this patient have a previous/current diagnosis of a neurodevelopmental disorder?

Autism Spectrum Disorder	☐ Yes	☐ No
Intellectual Disability	☐ Yes	☐ No
Developmental Delay	☐ Yes	☐ No
Genetic Disorder	☐ Yes	☐ No

Does patient have a previous/current diagnosis of a learning, behavioral or mental health disorder?

☐ No
☐ Yes If yes, please specify: _____

Does patient have a history of psychiatric hospitalization(s)?

☐ No
☐ Yes If yes, please specify date and location of hospitalization_____

Has patient ever been evaluated for Autism Spectrum Disorder?

☐ No
☐ Yes If yes, please specify: Date _____Provider/Agency_____

Outcome of evaluation: _____

Has this patient received any of the following services? (If yes, please send consult notes from subspecialties.)

Speech Therapy	☐ Yes	☐ No
Occupational Therapy	☐ Yes	☐ No
Behavioral Therapy	☐ Yes	☐ No
Neurology	☐ Yes	☐ No
Gastroenterology	☐ Yes	☐ No
Feeding team	☐ Yes	☐ No
Genetics	☐ Yes	☐ No
Neonatology	☐ Yes	☐ No
Endocrinology	☐ Yes	☐ No
Cardiology	☐ Yes	☐ No
Allergy	☐ Yes	☐ No

Request for Assessment/Diagnostic Services

Check all that apply

- ☐ Evaluation for suspected Autism Spectrum Disorder
- ☐ Evaluation for suspected Developmental Delays
- ☐ Evaluation for suspected Intellectual Disability
- ☐ Other _____

Symptoms/behaviors of concern to support request for evaluation:
_____

Request for Treatment Services

Current Diagnosis: _____Behaviors of Concern: _____

- ☐ **Developmental Pediatrician**
  - ☐ Medication management, developmental follow up, genetic testing, etc. for patients with Autism Spectrum Disorder and co-occurring ADHD and/or Anxiety.
  - ☐ Evaluation of ADHD only (please send any records of medication(s) tried in the past, if any)
- ☐ **Psychologist**
  - ☐ Behavior Therapy
  - ☐ Parent Child Interaction Therapy (PCIT)
- ☐ **Speech Therapy**
  - ○ Language Delay/Disorder
  - ○ Deficits in Social Skills
  - ○ Articulation Delay/Disorder
  - ○ Fluency Disorder

Signature of medical provider: _____ Date: _____