



THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Center for Child Health and Development / 2000 Olathe Blvd / MS 4003 / Kansas City, KS / 66160-7340

Please **fax** completed forms to: **913-588-5916**

If you have any questions please call 913-588-6300

PHYSICIAN REFERRAL FORM

This referral form is to be completed by the child's pediatrician or primary care physician only. For non-medical providers, please request the parent contact the child's primary medical care provider to complete the physician referral form.

For example:

Pediatrician

Primary Care Provider (PCP)

Nurse Practitioner or Physician Assistant

Psychiatrist

For more information, please visit our web page: <http://www.kumc.edu/school-of-medicine/cchd.html>

Date: _____

Name of Person Completing this form: _____

Name of Medical Provider: _____

Name of Practice:		
Address:		
City:	State:	ZIP Code:
E-mail:	Phone:	Fax:
Office Referral Contact Name:		

I have permission to share this information with the Center for Child Health and Development and for the CCHD to contact the parent to schedule an appointment. Yes No

Does this patient already have an appointment scheduled at the CCHD? Yes No

PATIENT INFORMATION

Name of parent/guardian: _____
FIRST *LAST*

Relationship to child:

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

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

Date of Birth: _____ Gender: Male Female

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

Primary language: English Spanish Other: _____

Child home address:		
City:	State:	ZIP Code:



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REASONS FOR REFERRAL

*For evaluations of ADHD or behavioral problems only, please refer to TUKHS Behavioral Pediatrics, 913-588-6300

Current Diagnosis:

- | | |
|---|---|
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Fragile X |
| <input type="checkbox"/> Developmental Delay/Delayed Milestones | <input type="checkbox"/> Down's Syndrome |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Other Learning Disability |
| <input type="checkbox"/> Speech/Language Delay | <input type="checkbox"/> Other Health Impairment/Concerns |
| <input type="checkbox"/> Mental Health Diagnosis | |

Notes about Diagnosis: _____

Reasons for Referral to the Center for Child Health and Development:

- | | |
|---|---|
| <input type="checkbox"/> Suspected Autism Spectrum Disorder | <input type="checkbox"/> Significant behavioral challenges |
| <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Other health impairments impacting development |
| <input type="checkbox"/> Speech/Language Delays | |
| <input type="checkbox"/> Delays in Social-Emotional Development | |

Referred to or receives the following services:

- Infant-Toddler Services (birth to 3)
- Early Childhood Special Education Services (3-5)
- Special Education Services (5-21)

Has the school completed an evaluation? Yes No Don't know

Medical Concerns:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Toileting |
| <input type="checkbox"/> Feeding | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gastro-intestinal | |

Other Medical Notes: _____

Is the child on medications? Yes No Don't know

Current Medications: _____

Signature of medical provider:

_____ Date: _____