# 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: **913-274-3546**
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
☐ Foster parent
☐ Other relative
☐ Agency Representative (Case Manager, Social Worker)

**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:**

- ☐ Autism Spectrum Disorder
- ☐ Developmental Delay/Delayed Milestones
- ☐ ADHD
- ☐ Speech/Language Delay
- ☐ Mental Health Diagnosis
- ☐ Fragile X
- ☐ Down's Syndrome
- ☐ Other Learning Disability
- ☐ Other Health Impairment/Concerns

**Notes about Diagnosis:** _____

_____

_____

_____

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

- ☐ Suspected Autism Spectrum Disorder
- ☐ Developmental Delays
- ☐ Speech/Language Delays
- ☐ Delays in Social-Emotional Development
- ☐ Significant behavioral challenges
- ☐ Other health impairments impacting 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:**

- ☐ Sleep
- ☐ Feeding
- ☐ Gastro-intestinal
- ☐ Toileting
- ☐ Other: _____

**Other Medical Notes:** _____

_____

_____

_____

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

**Current Medications:** _____

_____

**Signature of medical provider:**

_____ Date: _____