# Developmental Pediatric Medicine Referral Request Form

**Phone: (361) 694-5650 Fax: (361) 808-2063**

**Date requested: ___ /___ /___**

**Please note, we do not provide psychiatric services or behavioral therapy.**

## PATIENT INFORMATION:

Patient Name: ______________________ DOB: ____________ ❑ Male ❑ Female

Responsible Party: ______________________ (mother/father/other)

Patient's Address: ______________________ (City/State/Zip): ______________________

Best Contact Number: ______________________ Alternate Contact Number: ______________________

Interpreter Required? ❑ Yes ❑ No Language: ______________________

## INSURANCE INFORMATION:

Primary Insurance: ______________________ Secondary Insurance: ______________________

Subscriber's Name: ______________________ Subscriber's Name: ______________________

ID #: ______________ Group # ____________ ID # ______________ Group # ____________

## REASON FOR REFERRAL: ______________________

**Treatment goals may be obtained within a few visits. In those cases, the patient will be transitioned back to PCP to resume care.**

## SERVICE REQUEST:

### ❑ Consultation with DBP

Please include with the referral these findings and previously administered services:

- ECI
- Neurology
- Genetics
- Therapy/Counseling
- Psychologist/Psychiatrist
- School base services (504/ARD/IEP)
- Speech/OT/PT

***Check all that apply:***

❑ Fetal Alcohol Spectrum Disorder
❑ Disruptive Behaviors (ADHD and/or ODD)
❑ Autistic Behaviors (Diagnostic Evaluation)
❑ Tourette Spectrum Disorder (Tics, Anxiety, OCD, Attention Problems).
❑ Has diagnosis but concerns for co-morbidity (i.e. ADHD rule out Anxiety, Autism rule out ADHD)
❑ Mild Anxiety or Depression
❑ Second Opinion for diagnosis or treatment consideration
❑ Developmental Delay (DBP physicians use screening tools for development, academic functioning and neurodevelopment on a case-by-case basis.)

### ❑ Consultation with Psychologist

Please note:

- Two or more complex dx required for patient referral.
- Referral age is toddler to 12 years old.
- The only Medicaid Insurance accepted are Driscoll Health Plan and TMHP Medicaid. All other private insurance is Out of Network.
- All services are only for short term.

**For suspected but not yet diagnosed referral for autism, please send screening results for autism. Exp. - (MCHAT)**

***Check all that apply:***

❑ Learning Disabilities
❑ Autism Spectrum Disorders
❑ ADD, ADHD and Disruptive Behaviors
❑ Developmental Delay
❑ Anxiety and Depression
❑ Psychologist evaluation with IQ, cognitive, academic, language and autism testing

Suspected Diagnosis: ______________________

## REFERRING PRACTICE INFORMATION:

Referring Provider Name: ______________________ (Please print legibly)

Practice Name: ______________________ Practice #: ______________

Address: ______________________ Telephone: ______________ Fax: ______________

Medicaid PA good for __________ visits. Valid through ______________ (Date) __________

**PLEASE INCLUDE DEMOGRAPHICS INFO, COPY OF INSURANCE (both sides) & CURRENT CLINICALS and MEDICATION LIST**