INTAKE FORM TO BE COMPLETED BY PATIENT'S PRIMARY CARE PHYSICIAN ONLY

UMass Memorial Children's Medical Center

INTAKE FORM for ALL DBP Clinics

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (DBP)

Please Fax Intake Form to 774-455-4229

Questions Please Call 774-442-3028

This is not an urgent clinic: if safety concerns are dominant this is not an appropriate referral.

Please remind Parents we need packets mailed back within 3 months to schedule (for children older than 3y; those <3y can bring packets with them to appointment)

PATIENT INFORMATION

Patient Name: _____ PCP: _____

Gender: ☐ M ☐ F PCP phone #: _____

Patient DOB: _____ PCP fax #: _____

Patient Address: _____ Insurance: _____

_____ Insurance ID: _____

Parent/Guarantor Name: _____ Subscriber: _____

Parent/Guarantor DOB: _____ Subscriber DOB: _____

Phone: _____

Email: _____ Interpreter: _____

CLINICAL INFORMATION/PRESENTING PROBLEMS

Reason for Referral: Please mark and circle what is needed and complete:

Age Group: _____<3y; _____3-5y; _____6-18y

____Autism evaluation:

____Developmental/ Cognitive evaluation

____Growth and Nutrition Clinic

____Toileting Clinic

____Anxiety Clinic (until 10y)

____Already diagnosed with Autism: when…… where: ……Testing completed……

Specific concerns and questions: _____

_____

Does Child have a Sibling followed in DBP: ___Yes ___No Provider: _____

Does the Child have any other specific diagnoses? ___Yes* ___No

Explain: _____

Is the Child in Early Intervention: ___Yes ___No * if no, please refer if <3y?

Has Child had MCHAT/RF (<3 years): ___Yes ___No* Please complete before referral & attach.

Did the Child receive screening with the RITA-T (<3y): ____Yes _____No; Score: _____

Has this Child had a hearing test: ___Yes ___No * If no refer to Audiology 774-442-3996 or other for testing.

OFFICE USE:

Date referral received: _____ Date Packet mailed: _____

October 2018