UAMS | Schmieding Developmental Center

Patient Intake Information Sheet

This form must be filled out completely in order to have the information at hand for accurate and prompt scheduling of your patient.
Please fax this form, along with a separate PCP referral if required by insurance, to (479) 750-0323. The SDC will contact the parent/guardian to complete the Intake.

Today's Date: _____ Name of person completing form: _____

Referral Source Information:

Referral Source: _____ Phone: _____ Fax: _____

Referral Source NPI Number (Required): _____

General Information:

Child's Name: _____

Date of Birth: _____Sex: _____ Race: _____ Social Security Number: _____

Parent/Guardian's Name: _____

Relationship to child: (☐) Parent (☐) Grandparent (☐) Foster Parent (☐) Guardian Family's Primary Language: _____

Family's E-Mail Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Information:

Primary Care Physician: _____ Phone: _____ Fax: _____

List any serious illnesses or major medical problems: _____

Insurance Information:

Payment Source/Insurance Company Name: _____

Policy Holder's Name: _____

Policy/Group Number: _____ I.D. Number: _____

Medicaid Type: _____ Policy Number: _____

Reason(s) for Referral:

What is the major concern that has not already been addressed?

(☐) **Autism Spectrum Disorder (Autism, Pervasive Developmental Disorder, Asperger's)**

(☐) **Autism Screening Clinic (ages 18 months – 36 months / please include the MCHAT))**

(☐) **Developmental Delay (patient should be referred for Early Intervention Services, prior to SDC referral)**

(☐) **Learning Impairment (the school district will need to complete a psycho-educational evaluation first)**

(☐) **Comprehensive Neuropsychological Evaluation (provide records of the patients Neurological issues)**

(☐) **The Concussion Clinic / Call 479-750-0125 option 3 to Schedule an Appointment Today!**

(☐) **Psychiatric Care**

(☐) **Re-Evaluation of** _____

(☐) **Other:** _____

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