

THIS FORM MUST BE FILLED OUT COMPLETELY

Accepted referrals will be **PRIORITIZED** based on the Patient Intake & records justifying need for services.

Referral Checklist

- Patient Intake Demographics
 PCP Referral Records
 Fax to (479)750-0323

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

Who is requesting this appointment? Primary Care Physician Patient Other: _____

Referral Source Information:

Referral Source: _____ Phone: _____ Fax: _____

Referral Source NPI Number (Required): _____

General Information:

Child's Name: _____ DOB: _____

PLEASE ATTACH A DEMOGRAPHIC SHEET. INTAKES RECEIVED WITHOUT COMPLETE DEMOGRAPHICS WILL BE RETURNED.

Reason(s) for Referral:

- Psychiatric Care
- Autism Spectrum Disorder
- Developmental Delay (*children 5 years and under only*)
- Learning Impairment
- Comprehensive Neuropsychological Evaluation
- Medical Psychology (*Arkansas Children's Subspecialty Referrals Only*)
- The Concussion Clinic / Call 479-750-0125 option 3 to Schedule an Appointment Today!

Current Services: (*Check all that apply*)

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> NO SERVICES | <input type="checkbox"/> Early Childhood Developmental Services | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Resource Classes | <input type="checkbox"/> Physical Therapy Services | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Special Education Classes | <input type="checkbox"/> Occupational Therapy Services | <input type="checkbox"/> ABA Therapy |
| <input type="checkbox"/> Self-Contained Classes | <input type="checkbox"/> Speech/Language Therapy Services | |

Medical History: (*Check all that apply*)

BIRTH HISTORY: Unremarkable Premature: _____ weeks Traumatic Birth Alcohol/Drug Exposed

MEDICAL:

- | | | |
|--|--|---|
| <input type="checkbox"/> NO Medical Concerns | <input type="checkbox"/> Chronic Ear Infections/PE Tubes | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Frequent Strep Infections | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Gastrointestinal Issues | <input type="checkbox"/> Cardiac Issues |

MEDICAL TEST(S): Genetic Testing EKG ECHO EEG MRI CT X-Ray

CURRENT MEDICATIONS: List: _____

MENTAL HEALTH:

- | | | |
|---|--|--|
| <input type="checkbox"/> NO Mental Health Concerns | <input type="checkbox"/> ADHD | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Depression | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Learning Impairment/Dyslexia | <input type="checkbox"/> Oppositional Defiant Disorder | <input type="checkbox"/> Tic Disorder/Tourette's |

Comments: