Logo, company name

Description automatically generated

**Developmental Pediatric Clinic**

**New Appointment Referral Form**

Please fax completed form and medical records to our Central scheduling office at 402-955-6445

Thank you for the opportunity to participate in the care of your patient. We currently are accepting referrals for patients under the age of 5 years old.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Last Name: | First: | | | Middle: |
| Date of Birth: | Sex: Male Female | | | |
| Address:  City: State: Zip Code: | | | | |
| Parent(s)/Legal Guardian(s) Name: | | | | |
| Parent(s)/Legal Guardian(s) Phone Number(s): ( ) ( ) | | | | |
| Email: | | Insurance Plan: | | |
| Interpreter Needed: Yes Language: | | | Primary Care Physician Name: | |

|  |
| --- |
| Referring Provider Name: |
| Provider NPI#: |
| Fax Number: |

|  |
| --- |
| Reason for Referral: Is referral primarily for developmental or behavioral concerns and describe? |
| Is there a concern for autism spectrum disorder? |
| What support services does the patient receive through a school system or other community agency? |
| What other specialist are involved in the care of the patient? |
| Have any medications been prescribed for the patient for the reason you are referring? |

**Additional Information:** Patients will receive an intake packet to complete. The packet must be completed and returned to our clinic within 3 months. Once completed the patient will be added to the clinic waitlist. Patients will be scheduled when a new patient appointment is available. Wait time for a first visit can be 6 months after packet returned.

Developmental Pediatrics Team

For any questions please call: 402-955-3841