BOSTON MEDICAL CENTER DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (DBP) EXTERNAL REFERRAL INTAKE FORM

Fax this completed referral intake form to (617)-638-6756.

PATIENT INFORMATION				**PARENT INFORMATION**		
First Name				**First Name**		
Last Name				**Last Name**		
DOB				**Primary phone**		
Gender	male	female	other	**Secondary phone**		
Primary language				**Email**		
Interpreter required						
Which language?						
Legal guardian?	Mother	Father	Relative:	DCF	Other	
Patient insurance	Carrier			ID Number		
PRIMARY CARE CLINICIAN				**Reason for Referral/Question to Answer**		
First Name				Development		
Last Name				Speech/Language		
Office name				Behavioral		
Office address				Attention		
				Learning difference		
Primary phone & fax				Autism		
Email				Deaf and hard of hearing, to see Dr. Spellun		
				Other		

Briefly describe your concern/Question to Answer

If there is a **concern for autism spectrum disorder (ASD)**, please check all areas of concern

Social communication, describe

Repetitive behaviors, describe

Aggressive behavior towards others or self, describe

Eye contact	None	Minimal	Normal	
Social interactions	None	Minimal	Normal	
Sleep patterns	Disrupted		Normal	
Diet or oral intake	Restricted	Fair	Normal	
Hypo/hypersensitivity	Light	Sound	Textures	

Has patient been **previously evaluated for this concern by another clinician** (e.g., neurologist, psychologist, developmental pediatrician, school, other)?

No	If yes:	**Date**

Clinician's name/agency	**Testing type**

Has the patient **previously been evaluated at BMC DBP**?		
No	If yes:	**Clinician name**
Does patient have a **sibling previously been evaluated at BMC DBP**?		
No	If yes:	**Clinician name**

Most recent vision screening	Pass	Fail	Referral to:
Most recent hearing screening	Pass	Fail	Referral to:

Does patient have the following services?

Less than 3 years old:			**3 years and older:**		
Early Intervention?	Yes	No, why not?	Attends school?	Yes	No, why not?
EI agency name & town			**School name & town**		
EI staff name & phone			Teacher		
			Grade		
			Classroom size and/or type:		
Individual Family Service Plan (IFSP)			**504 plan?**	Yes	No, why not?
Yes			**IEP?**	Yes	No, why not?
No, why not?			**Eval in progress?**	Yes	
			No, why not?		

Additional services supporting child	**Agency**	**Frequency of Service**
Applied behavioral analysis (ABA)		
Speech and language therapy		
Occupational therapy (OT) therapy		
Physical therapy (PT) therapy		
MH counseling or therapy		
Other		

REQUIRED DOCUMENTATION must accompany this DBP referral intake form, in order for referral to be processed.

Encounter note that prompted referral

Results of validated Developmental/Autism screening tool: *MCHAT, STAT, PEDS, SWYC/POSI, CSBS, ASQ* (applicable for developmental delay or autism concern)

Results of validated ADHD screening tool: V*anderbilt, etc.* (applicable for ADHD concern)

<3 yo Current IFSP Individual Family Service Plan or Early Intervention agency contact info, see above

>3 yo Current IEP or 504 Accommodation Plan (school setting)

Current hearing and vision results (in office screening or consult reports)

Original diagnostic report, if seeking follow-up care

Thank you for collaborating with us to support your patients while they wait for an evaluation by the DBP service.

Fax this intake form to (617)-638-6756 in order for your patient's referral to be processed.

Fax ALL additional required documentation (not sent with this original intake referral form) to (617)-414-3661.

If you have any questions regarding this intake form, please call us at (617)-414-7418 or (617)-414-7947.

If you have a clinical concern you would like to discuss, call Dr. Augustyn at (617)-414-7418.