

Patient name  
DOB

Boston Medical Center  
Developmental Behavioral Pediatrics

Confidential  
Page 1

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

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

<b>PATIENT INFORMATION</b>				<b>PARENT INFORMATION</b>			
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			
<b>PRIMARY CARE CLINICIAN</b>				<b>Reason for Referral/Question to Answer</b>			
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			
<b>Briefly describe your concern/Question to Answer</b>							
<b>If there is a concern for autism spectrum disorder (ASD), please check all areas of concern</b>							
<b>Social communication, describe</b>							
<b>Repetitive behaviors, describe</b>							
<b>Aggressive behavior towards others or self, describe</b>							
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				
<b>Has patient been previously evaluated for this concern by another clinician (e.g., neurologist, psychologist, developmental pediatrician, school, other)?</b>							
No	If yes:	Date					
Clinician's name/agency				Testing type			

<b>Has the patient previously been evaluated at BMC DBP?</b>			
No	If yes:	Clinician name	
<b>Does patient have a sibling previously been evaluated at BMC DBP?</b>			
No	If yes:	Clinician name	
Most recent vision screening		Pass	Fail
Most recent hearing screening		Pass	Fail
		Referral to:	
		Referral to:	
<b>Does patient have the following services?</b>			
<b>Less than 3 years old:</b>		<b>3 years and older:</b>	
<b>Early Intervention?</b>	Yes	No, why not?	<b>Attends school?</b>
			Yes
			No, why not?
<b>EI agency name &amp; town</b>		<b>School name &amp; town</b>	
<b>EI staff name &amp; phone</b>		Teacher	
		Grade	
		Classroom size and/or type:	
<b>Individual Family Service Plan (IFSP)</b>		<b>504 plan?</b>	Yes
Yes		No, why not?	
No, why not?		<b>IEP?</b>	Yes
		No, why not?	
		<b>Eval in progress?</b>	Yes
		No, why not?	
<b>Additional services supporting child</b>	<b>Agency</b>	<b>Frequency of Service</b>	
Applied behavioral analysis (ABA)			
Speech and language therapy			
Occupational therapy (OT) therapy			
Physical therapy (PT) therapy			
MH counseling or therapy			
Other			
<b>REQUIRED DOCUMENTATION must accompany this DBP referral intake form, in order for referral to be processed.</b>			
<b>Encounter note that prompted referral</b>			
<b>Results of validated Developmental/Autism screening tool: MCHAT, STAT, PEDS, SWYC/POSI, CSBS, ASQ (applicable for developmental delay or autism concern)</b>			
<b>Results of validated ADHD screening tool: Vanderbilt, etc. (applicable for ADHD concern)</b>			
<b>&lt;3 yo Current IFSP Individual Family Service Plan or Early Intervention agency contact info, see above</b>			
<b>&gt;3 yo Current IEP or 504 Accommodation Plan (school setting)</b>			
<b>Current hearing and vision results (in office screening or consult reports)</b>			
<b>Original diagnostic report, if seeking follow-up care</b>			
Thank you for collaborating with us to support your patients while they wait for an evaluation by the DBP service.			
<b>Fax this intake form to (617)-638-6756 in order for your patient's referral to be processed.</b>			
Fax ALL additional required documentation (not sent with this original intake referral form) to (617)-414-7915.			
If you have a clinical concern you would like to discuss, call Dr. Augustyn at (617)-414-7418.			