pediatrix

DEVELOPMENTAL MEDICINE
OF DALLAS

Consultation Request Form

Date: _____
Patient name(s): _____ Date of birth: _____ ❒Male ❒Female
Parents name: _____ Mother: _____ Father: _____
Home phone: _____Cell phone: _____Work: _____
Home Address: _____
Insurance company: _____Insurance number: _____ID number: _____

Was the Child Ever in the NICU at Birth? ❒Yes ❒No ❒Unknown
Name Of NICU/Hospital_____

Primary Reason for Referral: (Check One)

❒Motor Delay ❒Speech Delay ❒Global Delay
❒Former Premature Infant ❒Learning Disability ❒Genetic Syndrome/Birth Anomaly
❒Autistic Spectrum Disorder (possible or diagnosed)
❒Other _____

Has this child been referred to:

❒ECI ❒Headstart
❒Preschool Program for Children with Disabilities ❒Special education in public school

Has this child had any diagnostic tests <u>related to the concern</u> completed in <u>your</u> office such as:

❒high resolution karyotype ❒other genetic testing
❒thyroid function ❒lead level
❒MRI ❒CT scan
❒VCUG ❒Scoliosis x-ray
❒Other lab work_____

Has this child received any other medical consultations? ❒Yes ❒No
If yes, please check all that apply:

Provider Specialty	*Provider*	*Provider Specialty*	*Provider*
❒Neurology	_____	❒Genetics	_____
❒Pulmonary	_____	❒ ENT	_____
❒Audiology	_____	❒Allergy/Im.	_____
❒Gastroenterology	_____	❒Craniofacial	_____
❒Other			

Has this child received any other therapeutic consultations? ❒Yes ❒No
If yes, please check all that apply and include facility:

❒PT _____ ❒Speech
❒OT _____ ❒Other _____

If after seeing your patient, we recommend diagnostic studies, or consultations, do you prefer we facilitate their completion, or do you prefer your office provide this service?

❒ My office will make the arrangements
❒ I prefer your office facilitate your recommendations

Physician's signature:_____Print physician's name: _____
Phone number:_____ Fax number: _____

Please fax completed form to 972-788-2798. If you have any questions call our office at 972-788-1858.
Thank you for your referral!