DOERNBECHER CHILDREN'S Hospital

OHSU

Hello,

Regarding Patient:

Date of Birth:

For a patient to be seen at the Child Development and Rehabilitation Center clinics (CDRC), the child must have developmental concerns and this referral form must be completed by a medical professional.

We do not provide services for or accept referrals for:

- Mental health/psychiatric evaluation without developmental concerns
- Educational testing in the absence of other developmental concerns (please refer to local school district)
- Seizure/epilepsy management (refer to Neurology)
- Specific genetic testing (refer to Genetics)
- Child abuse or trauma without developmental concerns
- Legal competency evaluations
- Diagnostic evaluation for Fetal Alcohol Spectrum Disorders with no developmental concerns

To speak with a physician, call **503-346-0644**
To refer a patient, fax **503-346-6854**.

**www.ohsu.edu/doernbecher/pediatric-advice-and-referrals**

Thank you,

OHSU Incoming Referral Center

Please review the enclosed instructions to refer your patient to OHSU's Child Development and Rehabilitation Center (CDRC)

DOERNBECHER CHILDREN'S Hospital
OHSU

# CDRC new patient referral form

For a patient to be seen at the Child Development and Rehabilitation Center clinics, this referral form must be completed by a medical professional.

We do not provide services for or accept referrals for:

- Mental health/psychiatric evaluation without developmental concerns
- Educational testing in the absence of other developmental concerns (please refer to local school district)
- Seizure/epilepsy management (refer to Neurology)
- Specific genetic testing (refer to Genetics)
- Child abuse or trauma without developmental concerns
- Legal competency evaluations
- Diagnostic evaluation for Fetal Alcohol Spectrum Disorders with no developmental concerns

– 1. Patient Demographics:

Preferred CDRC Location: ☐ Portland ☐ Eugene

| | | |
|---|---|---|
| Patient Name (Last Name, First Name): | Patient Sex: | Date of Birth: |
| Parent/Guardian Name: | Home Phone: | Cell: |
| Language(s) spoken at home: | Interpreter needed: ☐ Yes ☐ No | |
| Are you aware of any barriers to performing a successful telehealth visit with this family? ☐ Yes ☐ No<br>If yes, please provide details: | | |
| Home Address, City, State: | Insurance: | |
| Primary Care Professional: | Last Appointment with PCP: | |
| PCP Phone Number: | PCP Fax: | |
| Referring Professional (if not PCP): | Last Appointment with Referring Professional: | |
| Referring professional phone: | Referring professional fax: | |

**2. Does this patient have a current diagnosis?**

☐ No ☐ Yes, please specify:

**3. Please describe your concerns and clinical questions (ICD-10 codes are not sufficient):**

**If you are referring a patient to a specific program or service, please complete Item 4. You do not need to complete the remainder of the form.**

**If you are referring a patient for any other concerns, please complete Item 5 and the remainder of the form. You do not need to complete Item 4.**

**4. Please check item if you are referring to specific program or service:**

| | | |
|---|---|---|
| ☐ Audiology | ☐ Down Syndrome | ☐ Psychology |
| ☐ Congenital Brain Anomaly | ☐ Feeding Disorders | ☐ Rett |
| ☐ Craniofacial Disorders | ☐ Occupational Therapy | ☐ Speech Languagy Pathology |
| ☐ Developmental Evaluation Clinic/NICU Follow Up | ☐ Physical Therapy | ☐ Spina Bifida |

**5. Focus of this referral – please check all that apply:**

- ☐ Suspected/known motor delay/disorder (e.g., tone abnormality, coordination, cerebral palsy)
- ☐ Suspected or known delay in any area of development

  *Attach documentation of developmental delay(s), e.g., ASQ, IEP, clinic note*

*Areas of concern:*

- ☐ Behavioral
- ☐ Gross Motor
- ☐ Fine Motor/Sensory
- ☐ Learning Difficulty
- ☐ Hearing
- ☐ Speech Language
- ☐ Vision
- ☐ Other:

- ☐ Previously diagnosed developmental disorder (autism, ADHD, intellectual disability) with additional developmental concerns. Second opinions for Autism not provided.

  *Attach previous diagnostic evaluations, if available, and documentation of specific concerns*

- ☐ Specific concern for autism

  *If <5 years, attach documentation of behavior concerns or other assessment, e.g., M-CHATs, ASQ, etc.*

  *If >5 years, attach school or other assessments, if available, or detailed documentation or developmental concerns*

- ☐ Educational Eligibility of Autism needing medical confirmation or consultation

  *Attach school evaluations, IEP/IFSP, etc., if available*

- ☐ Concern of regression or loss of developmental skills (describe in Box 3 above)
  - ☐ Motor ☐ Language ☐ Other
- ☐ School difficulties related to developmental differences (5-17 years)
- ☐ Complicated ADHD concerns 5-17 years (e.g., failed at least two medications; additional developmental concerns; continued learning problems)

  *(We do not provide evaluations for ADHD without other concerns)*

**6. Current interventions:**

- ☐ Behavioral/Mental Health
- ☐ Educational Supports
- ☐ Hearing
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Language
- ☐ Other:

**7. Has this patient been referred elsewhere for these concerns?**

☐ No ☐ Yes – Where/When?

To speak with a physician, call **503-346-0644**
To refer a patient, fax **503-346-6854**

**www.ohsu.edu/doernbecher/pediatric-advice-and-referrals**