*****INTAKE FORM TO BE COMPLETED BY PATIENT'S PRIMARY CARE PHYSICIAN ONLY*****

INTAKE FORM for ALL DBP Clinics

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (DBP)

UMass Memorial Children's Medical Center

Please Fax Intake Form to 774-455-4229

Questions Please Call 774-442-3028

******This is not an urgent clinic: if safety concerns are dominant this is not an appropriate referral.***

PATIENT INFORMATION

Patient Name: _____ PCP: _____

Gender: ☐ M ☐ F PCP phone #: _____

Patient DOB: _____ PCP fax #: _____

Patient Address: _____ Insurance: _____

_____ Insurance ID: _____

Parent/Guarantor Name: _____ Subscriber: _____

Parent/Guarantor DOB: _____ Subscriber DOB: _____

Phone: _____

Email: _____ Interpreter: _____

CLINICAL INFORMATION/PRESENTING PROBLEMS

Reason for Referral: Please mark and circle what is needed and complete:

Age Group: _____<3y; _____3-5y; _____6-18y

____Autism evaluation

____Developmental/ Cognitive evaluation

____Growth and Nutrition Clinic (5 months to 7 years)

____Toileting Clinic (up to 9 years for day wetting and/or fecal soiling and any age for night wetting)

____Anxiety Clinic (up to 10 years)

____Already diagnosed with Autism: when…… where: ……Testing completed……

Specific concerns and questions: _____

_____

Does Child have a Sibling followed in DBP: ___Yes ___No Provider: _____

Does the Child have any other specific diagnoses? ___Yes ___No

Explain: _____

Is the Child in Early Intervention: ___Yes ___No if no, please refer if <3y

Has Child had MCHAT/RF (<3 years): ___Yes ___No Please complete & attach.

Did the Child receive screening with the RITA-T (<3y): ____Yes _____No; **IF YES USE RITA-T FAST TRACK FORM**

Has this Child had a hearing test: ___Yes ___No If no refer to Audiology 774-442-3996 or other for testing.

OFFICE USE:

Date referral received: _____ Date Packet mailed: _____

Form August 2021

October 2018