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

Children's Medical Center
UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER

INTAKE FORM for ALL DBP Clinics

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (DBP)

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: _____
Gender: ☐ M ☐ F
Patient DOB: _____
Patient Address: _____
_____
Parent/Guarantor Name: _____
Parent/Guarantor DOB: _____
Phone: _____
Email: _____

PCP: _____
PCP phone #: _____
PCP fax #: _____
Insurance: _____
Insurance ID: _____
Subscriber: _____
Subscriber DOB: _____

Interpreter: _____

CLINICAL INFORMATION/PRESENTING PROBLEMS

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

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

____Autism evaluation
____Developmental/ Cognitive evaluation
____Growth and Nutrition Clinic (5 months up to 7 years)

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; **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 April 2023

October 2018