WVUMedicine

Child Development Referral

PHONE: **304-598-4300** FAX: **304-293-1216** **PO Box 8012, Morgantown, WV 26506-8012**

Date of Referral: _______ _______ _______

Referring Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Address: ____

Reason for Referral: ____

PATIENT INFORMATION

Name: (Last) ______________________ (First) ______________________ (MI) ______

DOB: ______/______/______ Social Security #: ______________________

Address: ____

Home #: ______________ Cell #: ______________ Work #: ______________

INSURANCE INFORMATION

Insurance Co. Name: ____

Policy ID #: ______________________ Subscriber's Name: ______________________

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Current medical condition**
- ☐ **Medications list**
- ☐ **Lab results**
- ☐ **Growth charts**
- ☐ **EEG and EMG**
- ☐ **MRI and CT results (images on CD if possible)**
- ☐ **Prior testing records with date and location (cognitive/IQ, neuro, genetics, ophthalmology, speech, audio, counseling)**
- ☐ **Copy of insurance/Rx card**

Please indicate services receiving:

- ☐ **Birth to Three**
- ☐ **Counseling**
- ☐ **Pre-school special needs**
- ☐ **Speech**
- ☐ **Behavioral Interventionw**

Please read the following prior to sending the referral to ensure it is acceptable:

☐ **PT** ☐ **OT** ☐ **Behavioral Therapy/ABA**

YES	NO
Children ages 1 through 8 for question of Autism Spectrum	Children of any age withbehavior concerns, including anxiety, depression, bipolar disorder, and aggression
Children ages 5 through 11 with a concern of focus, attention, and learning	Motor problems, possible seizures - refer to Pediatric Neurology (304) 598-4835, option #3
	Isolated sleep issues - refer to Sleep Clinic