

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
☐ WHIN ☐ EPIC

If not, FAX or MAIL the following: _____

- | | |
|---|---|
| <input type="checkbox"/> Current medical condition | <input type="checkbox"/> Medications list |
| <input type="checkbox"/> Lab results | <input type="checkbox"/> Growth charts |
| <input type="checkbox"/> EEG and EMG | |
| <input type="checkbox"/> MRI and CT results (images on CD if possible) | |
| <input type="checkbox"/> Prior testing records with date and location
(cognitive/IQ, neuro, genetics, ophthalmology,
speech, audio, counseling) | |
| <input type="checkbox"/> 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 with behavior 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