Developmental Pediatrics Supplemental Referral Form

The more information provided by primary care about the child and the referral, the better able we are to expediently meet your patient's needs. This form was designed to be completed by the primary care provider. **Referrals with a clear referral question and detailed clinical notes can be prioritized and appointments made more efficiently.**

If this child has not yet reached his/her 3rd birthday, please make a referral to BabyNet at the same time as this referral. ***https://babynet.scdhhs.gov/prebabynet/***

If the child is between the ages of 3 and 5, please advise the parent to contact the local school district for an evaluation through Child Find.

Patient Name: ____ **DOB:**______________________

Current Diagnoses (including school diagnoses):____

Current Medications:____

Prior Medication trials:____

Has this patient been seen in our clinic previously? YES / NO

Does this child attend public school? Yes/No **If yes, which district do they attend?:**___________________

Does the child have an IEP at school? Yes/No **If yes, under what disability category?**__________________

What services is the child currently receiving: (please circle)

Speech OT PT ABA Counseling Psychiatry Feeding Therapy

What are the clinical symptoms of concern?____

Services Requested (Check all that apply AND describe):

- Evaluation for **ADHD** for these concerns:____
- Evaluation for **Developmental Delay** for these concerns:____
- Evaluation for **Learning Disability** for these concerns:____
- Evaluation for **Autism** (*if child has not already been diagnosed with autism)* for these concerns:__________
  ____
- **Autism Services Consultation** (*if child has already been diagnosed with autism, including a school diagnosis)* for these concerns:____
- **Medication Consultation** for these concerns:____

Office referral coordinator: Please confirm that the following have been attached to this referral (check will imply confirmation).

- ☐ New Patient Referral Fax Form and/or patient demographic sheet which includes guarantor information
- ☐ Diagnosis related to reason for referral
- ☐ Recent clinical notes related to the referral (please do not send unrelated clinical notes)
- ☐ Copy of front and back of insurance card

Thank you for your referral. When we receive the completed packet from the family, we will schedule an appointment for your patient. If you have a question about the status of a referral, please fax your request to 803-758-0142 in lieu of calling our office. We appreciate your patience and will process the referral as soon as possible.