*****INTAKE FORM TO BE COMPLETED BY PATIENT'S PRIMARY CARE PHYSICIAN/EARLY INTERVENTION COORDINATOR ONLY*****

UMass Memorial Children's Medical Center

INTAKE FORM for ALL DBP Clinics

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS (DBP)

RITA-T Fast Track

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: _____

Early Intervention (EI) Service Coordinator:

_____

EI Phone #:_____

EI Fax #:_____

Interpreter: _____

CLINICAL INFORMATION/PRESENTING PROBLEMS

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

____Autism evaluation:

Did the Child receive screening with the RITA-T (<3y): ____Yes _____No; Score: _____

Did the Child receive the MCHAT/RF (<3 years): ___Yes ___No* Please complete before referral & attach.

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

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?

OFFICE USE:

Date referral received: _____ Date Packet mailed: _____