JAMES L. DENNIS
DEVELOPMENTAL CENTER

UAMS
COLLEGE OF MEDICINE
DEPARTMENT OF PEDIATRICS
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Date: _____

NEW PATIENT REFERRAL FORM

The DDC does NOT provide diagnostic or treatment services for psychiatric diagnoses (e.g., depression, anxiety, bipolar disorder, etc) and is NOT the referral center for concerns of suicidal/homicidal ideation or mental health crises. If you are concerned that a child with those psychiatric issues also needs developmental assessment/referral to the DDC, please simultaneously refer to a psychiatric/mental health provider AND check this box, alerting us of this acute case: ☐

*****THIS FORM WILL BE CONSIDERED, ACCEPTED AND TREATED AS AN OFFICIAL MEDICAID REFERRAL*****

STEP 1: Patient Demographics and Insurance Information

Patient Name:		DOB:	Age:
Address:	City:	State:	Zip Code:
Parent(s)/Legal Guardian(s) Names:			
Phone Number(s): ( )	( )	( )	
Primary Insurance:		Policy #:	
Secondary Insurance:		Policy #	
Policy Holder's Name, DOB & Social Security #:			
Relationship to Patient:			
Primary Ins. Co. Phone # ( )		Secondary Ins. Co. Phone # ( )	
If the family you are referring does NOT speak English, what is their native language?			

STEP 2: Please check and complete ONE of the appropriate referral sections below:

O **Follow Up Appointment**

O Evaluation or Management of the following behaviors/concerns:

O Confirmation or Second Opinion of the Patient's Previous Diagnosis of:

O Therapy Services **ONLY** (*check requested therapy type below*):

- ◇ Feeding Problems
- ◇ Noncompliant/"Strong-Willed" Preschooler
- ◇ Autism w/ Anxiety & Social Skills Difficulty
- ◇ Medical Crisis and Loss Issues
- ◇ Diabetes Adjustment Issues
- ◇ ADHD Behavioral Issues
- ◇ Parent-Child Interaction Therapy

STEP 3: Physician Contact Information

PCP Name: _____ NPI#: _____

PCP Signature: _____

Phone #: _____ Fax #: _____

Referring Clinician Name: _____ NPI #: _____

PLEASE FAX THIS COMPLETED FORM AND ANY PERTINENT MEDICAL RECORDS TO DDC: (501) 978-6492