Developmental-Behavioral Pediatrics Clinic

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Consultation Request Form **Fax completed form and supplemental information to 858-496-9257**

Patient Information:

Child's Name: _____Date of Birth: / / Age: ____ Gender: ☐ M ☐F
Caregiver's Name: _____

Relation: ☐ Parent ☐ Foster Parent ☐ Other: _____

Will an interpreter be needed? ☐ No ☐Yes Which Language? _____
Mailing Address: _____
City _____ State _____ ZIP _____
Home ( ) _____Alt ( ) _____ Email: _____
In order to schedule an appointment, an insurance authorization must be in place. Please check if family plans to self-pay _____ Authorization required ___YES ____NO

Insurance Carrier/Type: _____
Subscriber Name: _____Subscriber ID: _____

*Please have your staff request an authorization for **ALL** of the following CPT codes, a level 5 consultation visit (99245), developmental screening (96110), developmental testing (96112, 96113x3), several follow-up visits (99215, 99214), and prolonged service with direct patient contact (99354).*

Referring Provider/Primary Care Physician:
Referring Provider Name _____Clinic Name _____
Phone number _____Fax number for reports _____

REQUIRED: Please describe in detail the primary reason for this consultation_____
_____
_____

****For concerns of abnormal development or learning problems, please ensure that referrals for appropriate concurrent services have also been submitted (e.g., school IEP request, speech therapy, etc.).****

Consultation concerns: ☐diagnosis ☐2nd opinion ☐medical workup ☐medication management ☐recommendations for services/resources

Diagnosis: ☐ Expressive language delay—315.31; ☐ Receptive language delay or expressive and receptive language delay—315.32 ☐ Gross motor delay—315.4 ☐ Fine motor delay —781.99 ☐ Social delay —301.6 ☐ ADHD-inattentive—314.00 ☐ ADHD-hyperactive/impulsive or combined type—314.01 ☐ Autism Spectrum Disorder—299.00 ☐ Anxiety—300.00 ☐ Depression—311 ☐ Learning difficulties—315.9 ☐ Academic underachievement —313.83 ☐ Oppositional behaviors/ODD—313.81 ☐ Intellectual disability —319 ☐ Feeding problems —783.3 ☐ Sleep problems —780.50

Is the patient currently under the care of a psychiatrist: ☐Yes (If yes, please provide contact information and records?)
☐ No

Other concerns with documented dx code_____
_____
_____

REQUIRED: Dx codes must be documented in EPIC referrals and on hard copy request.

***Note:** We are unable to evaluate children with complex or emergency mental health needs, or those taking multiple psychotropic medications. We do not provide comprehensive psychological testing, ongoing behavioral therapy or ongoing mental health counseling.*

_____ _____

Primary Care Physician's or Referring Provider's signature and specialty ***Date:***