SCHOOL OF MEDICINE
Carolina Institute for Developmental Disabilities

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SAVE

## CIDD CLINICAL REFERRAL FORM

**Today's Date** _____

**Is this request for services being made to address a preexisting developmental disorder (for example, intellectual disability, autism, or neurogenetic syndrome) or learning problem, or due to a concern regarding a possible developmental disorder?**

☐ Yes

☐ No

**Person completing the contact form**

☐ Medical, mental health, behavioral health, educational, or other service professional

☐ Parent, legal guardian, or other caregiver

☐ Self

**Has the patient been seen at UNCH Hospitals/UNC Healthcare previously for any reason?**

☐ Yes - If yes, ***do you know the patient's UNC Health Care Medical Record Number?***

☐ No ☐ *No* ☐ *Yes* _____

☐ Unknown

**Has the patient been seen at the UNC Carolina Institute for Developmental Disabilities previously?**

☐ Yes

☐ No

☐ Unknown

**Person Who Referred You to the CIDD?**

☐ Self

☐ Other _____

**Role of Referring Provider (if applicable):**

☐ Medicine/Physician

☐ Mental Health

☐ Educational Professional

☐ Allied Health Professional

☐ Other _____

Contact Information for Referring Provider: _____

**PATIENT/FAMILY INFORMATION:**
**Client/Patient Name:**

First: _____

Middle: _____

Last: _____

Nickname: _____

Age: _____ **Date of Birth**: _____

**Gender:**

☐ **Female**

☐ **Male**

☐ **Other** _____

**Current School Setting:**

☐ Not in school

☐ Primarily general education setting (regular classroom)

☐ Primarily special education setting (self-contained classroom)

☐ Home school

☐ Other _____

**Grade in School:** _____

**Name of PRIMARY CONTACT/Caregiver for Client:** _____

**Relationship to Patient**

☐ Self

☐ Parent

☐ Foster Parent

☐ Non-Parent Family Member

☐ Other _____

**Mailing Address:** _____
Street Address

_____ _____ _____
City State Zip Code

**Contact Information:** _____ _____
(Primary phone) (Secondary phone)

**E- mail address:** _____

**This email belongs to:**

☐ Patient ☐ Parent

☐ Other _____

**Name of Legal Guardian, if different from Primary Contact:** _____

**GUARANTOR INFORMATION:**

**Name of GUARANTOR (person responsible for payment):** _____

**Guarantor's Date of Birth:** _____

**Mailing Address:** ☐ **Address same as client/patient**

_____
Street Address

_____ _____ _____
City State Zip Code

(If applicable:)

**PRIMARY INSURANCE PROVIDER:** _____

**SECONDARY INSURANCE PROVIDER:** _____

**Name of PRIMARY CARE PROVIDER:** _____

**BACKGROUND INFORMATION:**

**Does the patient have any previous developmental, psychiatric, or learning disability diagnoses (e.g., autism spectrum disorder, intellectual disability, generalized anxiety disorder, etc.)?**

☐ Yes - Please complete the table below to the best of your ability ☐ No ☐ I don't know

| Diagnosis | Approximate Date of Diagnosis | Professional Disciplines Making the Diagnosis | Name of Professional (or Agency if known) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Does the patient have any previous medical diagnoses (e.g., deaf or hard of hearing, genetic diagnosis, traumatic brain injury, epilepsy, visual impairment)?**

☐ Yes ☐ No ☐ I don't Know

| Diagnosis | Approximate Date of Diagnosis | Professional Disciplines Making the Diagnosis | Name of Professional (or Agency if known) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Has the patient ever had any cognitive (also known as intellectual or "IQ") testing?**

☐ Yes ☐ No ☐ I don't know

| Type of Test (if known) | Approximate Date of Testing | Composite Test Score | School Based or Non-School Based |
|---|---|---|---|
| | | | ☐ School ☐ Other |
| | | | ☐ School ☐ Other |
| | | | ☐ School ☐ Other |

**Has the patient ever had any of the following educational assistance plans? (Check all that apply)**

☐ Individualized education program (IEP)

☐ Individualized Family Service Plan (IFSP)

☐ 504 Plan

☐ Other _____

**Is the patient currently involved in any of the following therapies or treatments? (Check all that apply)**

☐ Speech-language therapy

☐ Occupational therapy

☐ Physical therapy

☐ Mental health counseling/psychotherapy

☐ Psychiatric medication treatment

☐ Early intervention

☐ Special education instruction

☐ Home-based behavioral services

☐ Other _____

**APPOINTMENT NEEDS:**

**Does the patient/family need any special accommodations? For example, does the patient/family need an interpreter for the deaf, interpreter for another language, or is the child fearful of leaving parent, etc.?**

☐ Yes _____

☐ No

**What is the primary language spoken at home:**

☐ English

☐ Other _____

**Is there a particular team or professional you are wishing to meet with at the CIDD? Please note that we may not be able to accommodate all specific requests.**

☐ Yes _____

☐ No

**Are you requesting a diagnostic evaluation to assess for possible autism spectrum disorder? That is, are you questioning whether the patient has autism, Asperger's syndrome, or a pervasive developmental disorder?**

☐ Yes

☐ No

**Do you have concerns that the patient may have an intellectual disability/significant cognitive delays?**

☐ Yes

☐ No

**Are you seeking a developmental or cognitive (i.e., IQ) testing?**

☐ Yes

☐ No

**Are you seeking an academic/achievement evaluation? (If this is the only request, we recommend checking with your school district about a psychoeducational assessment. We currently offer self-pay options for academic evaluations since these are typically not covered by insurance.)**

☐ Yes

☐ No

**Are you seeking psychiatric medication management services?**

☐ Yes

☐ No

**Are you seeking behavior management consultation?**

☐ Yes

☐ No

**Are you seeking a speech-language evaluation/consultation?**

☐ Yes

☐ No

**Are you seeking therapy or treatment for autism spectrum disorder?** ***Please note we offer limited therapy and group intervention services. If you are seeking ongoing speech, physical, or occupational therapies, please consult your current medical/care providers for more appropriate referrals*****.**

☐ Yes _____

☐ No

**Are you seeking therapy or treatment for another developmental disability? Please note we offer limited psychotherapy and group intervention services. If you are seeking ongoing speech, physical, or occupational therapies, please consult your current medical/care providers for more appropriate referrals.**

☐ Yes _____

☐ No

**CURRENT CONCERNS**

**Do you have concerns about behavior (e.g., aggression, self-injury, disruptive behavior, etc.)?**

☐ Yes _____

☐ No

**Do you have mood-related concerns (e.g., anxiety, depression, etc.)?**

☐ Yes _____

☐ No

**Do you have concerns about learning (e.g., significant cognitive delays, reading, writing, memory, processing speed)?**

☐ Yes _____

☐ No

**Do you have speech-language or communication concerns (e.g., understanding what is said, expressive language, conversation difficulties)?**

☐ Yes _____

☐ No

**Do you have social development concerns (e.g., making friends, relating to others, social insight, etc.)?**

☐ Yes _____

☐ No

**Do you have motor/movement concerns (e.g., walking, balance, motor skills)?**

☐ Yes _____

☐ No

**Do you have any medical concerns (e.g., seizures, genetic disorders, medication concerns, toileting difficulties, etc.)?**

☐ Yes _____

☐ No

**What are the other main questions you hope to have answered by an evaluation or consultation at the CIDD? Please note any additional information relevant to your request.**

_____