Providence

# Providence Children's Development Clinic Referral Form

| **Patient and Referring Provider Information:** | |
|---|---|
| Patient Name: | Date of birth: |
| Address: | City/State: |
| Insurance Name/ID #: | |
| Parent: | Preferred language: |
| Guardian *(if different than parent)* or Caseworker (DHS custody): | |
| Preferred phone: | Secondary phone: |
| Preferred language: | |
| Referring Provider name: | Referring Provider phone: |

**Information to Include with Referrals:**

Provide the following to ensure timely processing of your referral:

- ICD.10 code; Chart notes, including a PCP visit documenting the referral concerns within the last four months
- Patient demographics, including updated insurance coverage
- Growth chart for all referrals unless available in Epic
- Results from any screening tests performed (ASQ, MCHAT, CAST, SWYC, POSI).

If available:

- Include educational testing reports, including eligibility for EI/ESCE/IEP/IFSP/504 services
- Fax any related documents that have not been scanned into our EMR as they are not viewable on our Epic platform

The above: ☐ Have been faxed ☐ Are available in Epic

**Referred Services:**

☐ **I approve assessments per intake**
☐ Developmental Pediatrics MD/NP
☐ Physical Therapy
☐ Occupational Therapy
  ☐ Fine/Visual Motor
  ☐ Sensory/Regulation

Speech-Language Therapy
  ☐ Augmentative Communication
  ☐ Articulation
  ☐ Stuttering
  ☐ Language
☐ Feeding Therapy (OT or Speech)

**Locations:**

**Providence St Vincent**
*Ph*: 503-216-2339
*Fax*: 503-216-6813

**Providence Child Center**
*Ph*: 503-216-2339
*Fax*: 503-215-2456

Visit Children's Health Provider Resources | Providence to see scope of service