SSM Health Cardinal Glennon Children's Hospital

Parent call: _____
Parent letter:_____
PCP Fax: _____
Date: _____

SSM Health Cardinal Glennon Children's Hospital

Knights of Columbus Developmental Center - Physician Referral Form

Thank you for choosing to refer your patient. Please complete this form and fax it to us at **314-678-4474**.

Patient Information

Name of Patient: _____ DOB:_____ Phone:_____

Parents/Guardian's Name: _____ Alternative Phone Number: _____

Patient Address (street, city, state, and zip): _____

Insurance: _____ Insurance ID #: _____

Consultation Request Information

Name of Referring MD: _____ Phone: _____ Fax: _____

Name of Referring PCP (if different than referring MD):_____

❑ Has family been informed of the reason for this referral?

❑ Has child been previously evaluated for/or diagnosed with autism (if so please call 577-6509 for further instructions)?

Reason for Referral

Must check **one** circle from the choices below. This will ensure that your patient is getting the specific services that they need. Checking more than one box will result in a delay in scheduling and need for a new referral form to be completed.

❍ **Assessment for Autism Spectrum Disorder**

- » Poor functional communication
- » Limited social interaction with peers and/or adults
- » Poor interest/desire to perform age appropriate activities of daily living (i.e. dressing)
- » Atypical behaviors which may include – hand flapping, hand/body posturing, peering at objects, limited or atypical play with toys

❍ **Assessment of Developmental Delays**

- » Persistent delays in at least two areas (fine motor, gross motor, speech, language)
- » May have associated physical impairment, chromosome/genetic abnormality, neurologic signs
- » Social delays consistent with developmental level of functioning

❍ **Occupational Therapy Assessment – fine motor, sensory, self-care, feeding**

❑ Has patient been assessed by OT or is currently receiving OT services

- » Sensory processing difficulties – bothered by or seeking sound/touch/movement, constantly on the move, food texture/taste sensitivities
- » Poor functional daily living skills – buttoning, bathing and/or dressing difficulties, self-feeding difficulties
- » Fine motor limitations – pencil grasp, difficulty manipulating objects/play materials

Required Orders: Evaluations often include multiple disciplines. In order to complete the comprehensive evaluation, please sign orders for both speech and occupational therapies below:

1. Speech and Language Therapy Evaluation and Treatment Diagnosis _____
2. Occupational Therapy Evaluation and Treatment Diagnosis _____

Signature of Referring Physician: _____ Date: _____

The following needs would be better served through referral to the following departments:

1. Psycho-Educational Testing ➡ Psychology Department | 314-577-5667
2. ADHD Testing ➡ Psychology Department | 314 577-5667
3. Behavior Treatment ➡ Psychology Department | 314-577-5667
4. Speech/Language Delays Only ➡ Speech Department | 314-577-5669
5. Gross Motor/Fine Motor Difficulties ➡ PT and OT Therapy Department | 314-577-5669

Note: Psychology Department is not a provider for Illinois Medicaid Insurance Plans.

Screening Completed

Please check all screenings which have been completed and indicate whether the child passed or failed. Please send copies of evaluations.

❑ Modified Checklist for Autism in Toddlers (M-CHAT) ❍ Pass ❍ Fail

❑ Conner's/Vanderbilt Behavior Ratings Scales Parent: ❍ Pass ❍ Fail Teacher: ❍ Pass ❍ Fail

❑ Ages and Stages Questionnaire (ASQ) ❍ Pass ❍ Fail

❑ Social and Communication Questionnaire (SCQ) ❍ Pass ❍ Fail

Pertinent Medical History (including psychiatric hospitalization):

_____

_____

Concerns Related to Family/Social History (E.g., Abuse/Neglect, Out of Home Placement):

_____

_____

Current Diagnoses (if any):

Diagnosis: _____ ICD-10 Code: _____

Diagnosis: _____ ICD-10 Code: _____

Diagnosis: _____ ICD-10 Code: _____

Laboratory or Radiological Studies Completed

Please check studies which have been completed, and indicate whether they were normal or abnormal. Specify all abnormal results.

❑ EEG ❍ Normal ❍ Abnormal Date Completed: _____

❑ MRI brain ❍ Normal ❍ Abnormal Date Completed: _____

❑ Vision Screen ❍ Normal ❍ Abnormal Date Completed: _____

❑ Hearing Screen ❍ Normal ❍ Abnormal Date Completed: _____

❑ Chromosomal Testing ❍ Normal ❍ Abnormal Date Completed: _____

Thank you for your referral to the Knights of Columbus Developmental Center
SSM Health Cardinal Glennon Children's Hospital
314 577-5609