Division of General Pediatrics/
ADHD Diagnostic Clinic

PHOENIX CHILDREN'S Medical Group®

REFERRAL SCREENING FORM

Name: ______________________
MR #: ______________________
DOB: ______________________
or Apply Patient Label

☐ **APPROVED** ☐ **SEE BELOW**

Robin Blitz, MD
A. D. Jacobson, MD
Sara Bode, MD
Jodi Meadows, MS, RN, CPNP

Reason for Referral: ____

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ICD9: _________ ☐ **Office Consult (99241-99245)** ☐ **Office Follow-ups (99212-99215)** ☐ **Routine** ☐ **Urgent**

PHYSICIAN SIGNATURE: ______________________ **DATE:** ___________ **TIME:** ___________

CHILD'S NAME: ______________________ **DOB:** ______________________
PARENT/GUARDIAN NAME: ______________________ **PCP:** ______________________
PARENT PHONE: ______________________ **PCP PHONE:** ______________________
INSURANCE PLAN: ______________________ **PCP FAX:** ______________________
OTHER ILLNESSES? ____
WHAT MEDICATIONS IS THE CHILD ON? ____
GRADE IN SCHOOL? ____
IN THERAPIES? ____
IS INTERPRETER NEEDED? IF SO, WHAT LANGUAGE: ____

You may fax supporting medical records in lieu of completing the questions above.
Please have your patient bring all records (school, therapies, other doctors, labs, radiology reports) that they have.

Thank you for your referral to Phoenix Children's Hospital, ADHD Diagnostic Clinic. In an effort to ensure that children with learning and/or behavioral issues are best served, all appointment referrals are reviewed by a physician prior to scheduling an appointment. **After review, this form will be returned to you with the following information regarding your patient**.

- ☐ We have reviewed the referral and your patient will be scheduled in the ADHD Diagnostic Clinic.
- ☐ We have reviewed the referral but feel that your patient would be best served by:
  - ☐ Psychology for learning disability, MR or autism spectrum assessment(s).
  - ☐ Psychiatry for evaluation and treatment of behaviors including depression, anxiety, Bipolar disorder or other psychiatric illness. *(Please note: Patients with AHCCCS must be referred to a Magellan provider. PCH is not a contracted provider.)*
  - ☐ Neurology
  - ☐ School Psychologist
  - ☐ Other
- ☐ The provider is unfortunately not contracted with your patient's insurance plan.
- ☐ Additional information is required: (Please return information; fax 602-546-0222.) ______________________

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1919 E. Thomas Road ▪ Bldg. B, 2nd Floor ▪ Phoenix, AZ 85016 ▪ (P) 602-546-0945 ▪ (F) 602-546-0222
5131 E. Southern Avenue, ▪ Mesa, AZ 85206▪

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