



**Anna Shaw  
Children's Institute**

1201 Burleyson Road, Dalton GA 30720

Phone: 706.226.8900

Fax: 706.226.8905

**We accept referrals for  
New Patients Ages 0 – 10 yrs**

<p><b>Referral Request Form</b>  <b>Fax/Scan the following to 706.226.8905</b></p> <ol style="list-style-type: none"> <li>1. This completed referral form</li> <li>2. Copy of electronic medical record demographic page</li> <li>3. Copy of <i>front and back of insurance card</i> and</li> <li>4. Most recent H&amp;P</li> </ol>
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Date of Request: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Contact Number \_\_\_\_\_

for Parent/Guardian ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<b>**All Care Services Require a *Diagnosis, PCP Referral (as below) and Physician's Signature (as below)</b>	
*Diagnosis:	*Diagnosis:
<p style="text-align: center;"><b>Developmental/Behavioral Pediatrics</b></p> <input type="checkbox"/> Developmental Evaluation <ul style="list-style-type: none"> <li><input type="checkbox"/> Global delays</li> <li><input type="checkbox"/> Related to genetic syndrome</li> <li>_____</li> <li><input type="checkbox"/> Prematurity (Birth @ _____ wks gestation)</li> </ul> <input type="checkbox"/> ADD/ADHD Evaluation <input type="checkbox"/> Autism Evaluation <ul style="list-style-type: none"> <li><input type="checkbox"/> New Evaluation</li> <li><input type="checkbox"/> Previously Diagnosed</li> </ul> <input type="checkbox"/> Other _____	<p style="text-align: center;"><b>Therapy Services</b></p> <input type="checkbox"/> Speech Therapy Evaluation <ul style="list-style-type: none"> <li><input type="checkbox"/> Delays</li> <li><input type="checkbox"/> Feeding Therapy due to poor motor control</li> </ul> <input type="checkbox"/> Physical Therapy Evaluation <input type="checkbox"/> Occupational Therapy Evaluation <ul style="list-style-type: none"> <li><input type="checkbox"/> Sensory Issues</li> <li><input type="checkbox"/> Fine motor delays</li> <li><input type="checkbox"/> Feeding Therapy due to food aversion</li> </ul> <input type="checkbox"/> Other _____
Additional Information (Syndromes, Diagnostic Results of Previous Genetic Testing, etc):	

\*\*I, the Referring Physician (Please Print) \_\_\_\_\_ am referring this child to the Anna Shaw Children's Institute for the evaluation(s) and treatment(s) as selected above.

Contact Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

\*\*Physician's Signature \_\_\_\_\_ Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Additional Contact at Referring Office \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

***Thank you! Your attention to detail permits our attention to be on the children and families  
Following completion of the initial appointment with the provider at the Anna Shaw Children's Institute, you will receive a summary letter from our office with the impression and plan for evaluations to assess this child.  
Following completion of the evaluations/assessments, a detailed report will be sent to the referring provider-it may take several months to receive this detailed report. The report will be sent to you as soon as it is ready.***