

1201 Burleyson Road, Dalton GA 30720

Phone: 706.226.8900

Fax: 706.226.8905

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

Referral Request Form
Fax/Scan the following to 706.226.8905

1. This completed referral form
2. Copy of electronic medical record demographic page
3. Copy of **front and back of insurance card** and
4. Most recent H&P

Date of Request: ____/____/____

Patient Name: _____ Birth Date: ____/____/____

Contact Number

Parent/Guardian Name: _____ for Parent/Guardian (____) _____

Address: _____

City: _____ State: _____ Zip: _____

****All Care Services Require a *Diagnosis, PCP Referral (as below) and Physician's Signature (as below)**

<p>*Diagnosis: _____</p> <p style="text-align: center;">Developmental/Behavioral Pediatrics</p> <p><input type="checkbox"/> Developmental Evaluation</p> <p style="margin-left: 20px;"><input type="checkbox"/> Global delays</p> <p style="margin-left: 20px;"><input type="checkbox"/> Related to genetic syndrome</p> <p style="margin-left: 20px;">_____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Prematurity (Birth @ _____ wks gestation)</p> <p><input type="checkbox"/> ADD/ADHD Evaluation</p> <p><input type="checkbox"/> Autism Evaluation</p> <p style="margin-left: 20px;"><input type="checkbox"/> New Evaluation</p> <p style="margin-left: 20px;"><input type="checkbox"/> Previously Diagnosed</p> <p><input type="checkbox"/> Preschool Behavioral Clinic</p> <p><input type="checkbox"/> Other _____</p>	<p>*Diagnosis: _____</p> <p style="text-align: center;">Therapy Services</p> <p><input type="checkbox"/> Speech Therapy Evaluation</p> <p style="margin-left: 20px;"><input type="checkbox"/> Delays</p> <p style="margin-left: 20px;"><input type="checkbox"/> Feeding Therapy due to poor motor control</p> <p><input type="checkbox"/> Physical Therapy Evaluation</p> <p><input type="checkbox"/> Occupational Therapy Evaluation</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sensory Issues</p> <p style="margin-left: 20px;"><input type="checkbox"/> Fine motor delays</p> <p style="margin-left: 20px;"><input type="checkbox"/> Feeding Therapy due to food aversion</p> <p><input type="checkbox"/> Other _____</p>
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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.