CENTER FOR CHILDREN WITH SPECIAL NEEDS

Physician Referral Questionnaire

Tufts Children's Hospital

Child's Name: ____________________ Date of birth: ____________

Thank you for your referral to the CCSN. We understand that you would like us to evaluate this patient and would appreciate the following information to help us with the assessment process. Please return this form to email address CCSNForms@tuftsmedicalcenter.org or fax number (617)636-5621.

Physician Name: ____________________ Date: ____________

Contact name for follow-up questions: ____________________ Phone: ____________

Email address: ____________________ Fax: ____________

Primary reason(s) for referral:

☐ **Identify diagnosis:** Please indicate suspected dx you are concerned about and why?

____

____

☐ **Medication consultation/management:**
Has the child been seen by a psychiatrist ? ☐ YES ☐ NO If yes, what was the outcome?

____

____

Has the child had a medication trial? If so what medications and what response has pt had?

____

____

☐ **Ongoing management of known developmental disability**: What is the disability:

____

____

☐ **Identify needed school services.** Has child been evaluated by the school? ☐ YES ☐ NO
Is child on an IEP? ☐ YES ☐ NO

☐ **Additional Reason(s):**

____

____

____

____

continued

Please indicate any other specialists who have participated in the care of these concerns:

Please estimate the level of child's impairment: ☐ Mild ☐ Moderate ☐ Severe

Please indicate the urgency level of this referral: ☐ Routine ☐ Moderate ☐ Urgent

What aspects of social or family history should we know?

What aspects of medical history should we know?

Is the child currently on any regular medications not listed above? ☐ No ☐ Yes:

Sensory Testing	Date	Results
Vision Testing		
Hearing Testing		