Dear Referring Provider,

Thank you for referring to the Developmental Behavioral Pediatric Clinic at the Kentucky Children’s Hospital. Please review the following guidelines for referrals to our clinic:

- **We accept referrals for children with neurodevelopmental concerns for the following:**
  - Autism Spectrum Disorder
  - Complex/Complicated Attention Deficit Hyperactivity Disorder
  - Developmental difficulties associated with complex medical conditions such as genetic disorders or congenital heart defects.
  - Developmental Delays (involving cognition, speech, language, motor)
  - Intellectual Disabilities

- **We do not accept referrals for children over the age of 12 for ADHD.**
  - Children age 12 or over can be referred to the UK Adolescent Medicine Clinic for Evaluation and Treatment. Please call (859) 323-5643 to schedule an appointment.

- **We do not see children with psychiatric or behavioral complaints who do not have a Developmental Behavioral or Neurodevelopmental diagnosis. These include but not limited to:**
  - Anxiety
  - Bipolar Disorder
  - Depression
  - Obsessive Compulsive Disorder
  - Oppositional Defiant Disorder
  - Schizophrenia
  - Treatment for past abuse or trauma

- **We do not evaluate for or treat children or adolescents with isolated or Specific Learning Disorders such as Dyslexia, Reading, Math and/or Written Expression Disorders. For these concerns, please contact the child’s local school district.**

Children who **do not** have a primary Developmental Behavioral or Neurodevelopmental diagnosis, who are in need mental health treatment, should be referred to a mental health provider. If the patient is in need of mental health treatment and/or diagnosis, we encourage them to consult their health insurance provider for a list of covered providers in their area. If they prefer to be seen in Lexington, they can be referred to UK Psychiatry. UK Psychiatry accepts referrals directly from the patient family. The family should verify that UK Psychiatry is a
covered provider with their health insurance plan prior to scheduling an appointment. Appointments can be made with UK Psychiatry by having the family call (859) 323-6021 to schedule a new patient appointment.

For the child to be considered for evaluation and treatment in the Developmental Behavioral clinic, please send all supporting information about the child to (fax) (859) 218-7487 including:

1) Past medical history relating to the referral concerns including office notes, growth charts, developmental screens and previous outside evaluations. This may include notes from Speech, OT, PT or behavioral therapies.
2) School records with past psychoeducation, IQ or school academic testing.
3) Any records related to school services, including IEP and 504 documents.
4) A list of history of past and current medications the child is taking to assist with their problems.

Once information about the child’s developmental behavioral concern has been received, our providers and staff will review the records to determine if our clinic is the best resource for your patient. If the patient referral is accepted for evaluation and treatment, we will notify your office and we will mail the patient’s family a packet that will need to be returned and reviewed before an appointment can be scheduled. Please verify the phone number and request an emergency contact, so we may contact the patient and their family directly. If it is felt that our clinic is not the best resource for evaluation and treatment, we will contact your office.

Thank you for your referral. If you have any questions, feel free to contact our office at (859) 257-8992.

Sincerely,

Developmental Behavioral Pediatrics
Developmental Behavioral Clinic Referral Form

Patient Information

Patient Name: ___________________________________  Patient Date of Birth: _______________________
Parent/Guardian’s Name: _________________________ Relationship to Patient: _____________________
Patient Phone Number: ____________________________ Alternate Phone Number: ___________________
Patient Address: ___________________________________________________________________________
___________________________________________________________________________

Patient Insurance: ________________________________
Group Number: __________________________________ Member Number: _________________________
Primary Insured Party: _____________________________ Guarantor: ___________________________

Emergency Contact for Patient: ______________________ Relationship to Patient: _____________________
Phone Number for Emergency Contact: ________________________________________________________

Referral Information

Name of Referring Physician/Provider/Practice: _________________________________________________
Address: ____________________________________________________________________________
Telephone Number: ______________________________ Fax Number: ______________________________

Primary Care Provider Information

Name of Referring Physician/Provider/Practice: _________________________________________________
Address: ____________________________________________________________________________
Telephone Number: ______________________________ Fax Number: ______________________________

For Referring Physician/Provider to Complete

What condition do you want our providers to evaluate for?

☐ Autism Spectrum Disorder
☐ Intellectual Disability / Global Developmental Delay / Cognitive Delay
☐ ADHD
☐ Motor Delay  Speech Language Delay  Other Concern ________________________________

What signs, symptoms, behaviors or developmental concerns are present?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Physician/Provider Signature: ____________________________ Date: ____________________________

Please fax completed form to Developmental Behavioral Pediatrics at (859) 218-7487