The Center for Children with Special Needs at Tufts Children's Hospital
800 Washington #334, Boston, MA 02111
Phone: (617) 636-7242 Fax: (617)636-5621 Email: CCSNForms@tuftsmedicalcenter.org

Child's Name:_____ **DOB:**_____

Physician Referral Questionnaire

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 the email or fax number listed above.

Date: _____ Physician Name: _____
Who can we contact at your practice if there are follow-up questions?_____
Phone #: _____ Fax #: _____ Email: _____

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)**: _____
_____

- 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		