DOERNBECHER CHILDREN'S Hospital

OHSU

Re: Patient's Name : _____

Date of Birth : _____

Dear Parent, Guardian or Provider:

For a patient to be seen at the Child Development and Rehabilitation Center (CDRC) clinics, the child must have **developmental concerns** and this referral form must be completed by a medical professional.

We do not provide services for or accept referrals for:

- Educational testing/dyslexia (please refer to local school district)
- Seizure/epilepsy management (refer to Neurology)
- Specific genetic testing (refer to Genetics
- Child abuse or trauma assessment
- Legal competency or custody evaluations
- Diagnostic evaluation for Fetal Alcohol Spectrum Disorders
- Diagnostic evaluation for PANDAS
- Second opinion/re-evaluations for autism
- Initial diagnostic ADHD evaluations without other developmental concern
  ABA services

We do not provide Mental Health Assessment without an explicit history of developmental concerns and cannot provide support for complex psychiatric disorders.

Please Contact OPAL-K (855-966-7255) if your patient is experiencing a mental health crisis that includes:

- Hallucinations
- Suicidal ideation
- Risk of harm to self or others
- Need for, or recent history of, in-patient hospitalization

To speak with a physician, call **503-346-0644;** to refer a patient, fax **503-346-6854** or visit: **www.ohsu.edu/doernbecher/pediatric-advice-and-referrals**

Thank you,

CDRC Incoming Referral Center

Enclosure/Attachment: CDRC New Patient Referral Form (provider must complete)

CDRC New Patient Referral Form

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Preferred CDRC Location: ☐ Portland ☐ Eugene

OPAL-K Consultation: ☐ No ☐ Yes (Date of Consultation: _____)

1. Patient Demographics

Patient's Name (Last Name, First Name)	Patient's Sex: Pronouns:	Date of Birth:
Parent's/Guardian's Name:	Home Phone:	Cell:
Secondary Contact (if applicable):	Home Phone:	Cell:
If in DHS Custody, Guardian's Legal Name:	Home Phone:	Phone:
Language(s) spoken at home:	Interpreter needed: ☐ No Yes Language: _____	
Primary Care Professional's (PCP's) Name:	Phone/Fax:	Last appointment with PCP:
Referring Professional (if not PCP):	Phone/Fax:	Last appointment with referring professional

2. Referral Information

Please check the specific program(s) or service(s) you are referring the patient to:

☐ Audiology	☐ DEC/NICU Follow Up	☐ Physical Therapy
☐ Autism	☐ Down Syndrome	☐ Psychology
☐ Behavioral Pediatrics	☐ Feeding Disorders	☐ Rett
☐ Child Development	☐ Neurodevelopment	☐ Speech Language
☐ Craniofacial Disorders	☐ Occupational Therapy	☐ Spina Bifida
		☐ Lifespan Transition (OT/SW)

3. Focus of Referral, please check all that apply:

☐ Suspected/known motor delay/disorder
e.g., tone abnormality, coordination, cerebral palsy

☐ Suspected/known delay in any area of development
Attach documentation of developmental delay(s), e.g., ASQ, IEP, chart note

☐ Complicated ADHD concerns, 5-17 years
CDRC does not provide evaluations for ADHD without other concerns
e.g., failed at least two medications; additional developmental concerns; continued learning problems

☐ Other behavioral concerns, please specify:

4. Areas of Concern, check all that apply *(attach MCHAT and/or Other Evaluation, if available)*

Risk Factors:

☐ Trauma or complex social history

☐ Sibling/parent with ASD/DD

Prior Diagnosis:

☐ ADHD

☐ Anxiety/depression/mood

☐ Autism

☐ Developmental delay

☐ Intellectual disability

☐ Language disorder

☐ Learning disability

☐ Other: _____

Cognition:

☐ Delays in multiple areas

☐ Regression in skills

Area/age of regression: _____

Learning:

☐ Learning challenges

☐ School/learning supports (IEP/IFSP)

Eligibility: _____

Communication:

- ☐ Minimal verbal communicator
- ☐ Does not direct speech to others
- ☐ Echoed/scripted speech
- ☐ Does not understand instructions
- ☐ Does not understand gestures
- ☐ Does not use gestures/pointing

Socialization/Behavior:

- ☐ Poor eye contact
- ☐ Does not respond to/ignores others
- ☐ Trouble making/keeping friends
- ☐ Immature for age
- ☐ Tantrums/aggression/behavior problems
- ☐ Hyperactivity/inattention
- ☐ Better with familiar people/non-peers
- ☐ Challenges with turn-taking

Restricted Interests:

- ☐ Unusual or repetitive play (lining up/sorting/spinning toys)
- ☐ Repetitive movements (hand flapping, rocking, spinning)
- ☐ Rigid routines and transitions
- ☐ Strong interest or advanced knowledge Example: _____
- ☐ Peering/squinting at objects
- ☐ Sensory differences
- ☐ Other: _____

Additional Symptoms or Areas of Concern:

5. Current interventions

- ☐ Audiology
- ☐ Behavioral/mental health
- ☐ Educational supports
- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Speech language pathology
- ☐ Other: _____

6. Has this patient been referred elsewhere for these concerns?

☐ No ☐ Yes, if yes, please specify when and where.

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