PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: _________________ ( ) Initial ( ) Follow-up

Referring Physician Name: ____________________________

Address: ____________________________

(Street/PO Box) ____________________ City __________ State __________ Zip __________

Fax: ______ Phone: (______) ____________________________

DOB: __________

Patient’s Name: ____________________________ Address: ____________________________ Phone: __________________

Parent’s Name: ____________________________ Date(s) Patient Seen: _______________

Reason(s) for Referral: ____________________________

Any Specific Questions or Requests ______________________________________________________

Referring Physician’s Printed Name/Signature

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of this form to retain in the patient’s record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.

Consultant’s Report

Date(s) Patient Seen: _______________

☐ Patient did not make appointment. ☐ Patient made an appointment but did not keep appointment.

☐ Patient not seen within 60 days.

Initial Diagnoses:
1. ____________________________
2. ____________________________
3. ____________________________

Recommendations: ____________________________

Medications Prescribed: ____________________________

Follow-up Arranged or Provided by Consultant: ____________________________

☐ Further diagnostic testing
☐ Individual therapy
☐ Family therapy
☐ Medication management

Other Care Needed:

☐ Group therapy
☐ Lab tests
☐ Return visit

☐ Medication management by PCC
☐ Referrals recommended
☐ Follow-up recommended

☐ Other

Name (type or print) ____________________________

FAX to _________ Signature ____________________________

Contact # _________

Add disclaimer statement per your institution here: ____________________________

doi: 10.1542/peds.2010-0788Q

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Supplemental Appendix S11: Primary Care Referral and Feedback Form

Pediatrics 2010;125;S172
DOI: 10.1542/peds.2010-0788Q

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/125/Supplement_3/S172.citation