PRIMAR Y CARE REFERRAL AND FEEDBACK FORM

Date: ____________________  ( ) Initial  ( ) Follow-up

Referring Physician Name:

Address: __________________________  City  State  Zip

Fax: (_____ )  Phone: (_____ )

Patient's Name: __________________________  DOB:

Parent’s Name: __________________________  Address: __________________________  Phone:

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
❑ Group therapy
❑ Lab tests
❑ Return visit

Other Care Needed:

❑ Medication management by PCC
❑ Referrals recommended
❑ Follow-up recommended
❑ Other

Name (type or print) __________________________  Signature __________________________

FAX to # __________________________  contact person __________________________

Add disclaimer statement per your institution here:

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Supplemental Appendix S11: Primary Care Referral and Feedback Form

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http://pediatrics.aappublications.org/content/125/Supplement_3/S172.citation