PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: ________________  ( ) Initial  ( ) Follow-up

Referring Physician Name: ________________________________

Address: ____________________________  (Street/PO Box)  ____________________________
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) ____________________________
FAX to ____________________________  Signature ____________________________

# ____________________________  contact person

Add disclaimer statement per your institution here: ____________________________

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DEDICATED TO THE HEALTH OF ALL CHILDREN™
Supplemental Appendix S11: Primary Care Referral and Feedback Form

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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