



State of Alaska
Neurodevelopmental Outreach Clinic
Medical Provider Referral Form

Please print, fill out, and fax with attachments to Sue Armstrong at 800-466-1538

Patient's name: _____ Patient's D O B: _____ M / F

Parent / guardian name and contact information: _____

Patient's home region (circle one): Barrow Bethel Dillingham Fairbanks Homer
Juneau Ketchikan Kodiak Kotzebue Mat-Su Nome Other: _____

Primary reason for neurodevelopmental referral (check one):

- | | |
|---|---|
| <input type="checkbox"/> Autism rule-out | <input type="checkbox"/> Autism follow-up |
| <input type="checkbox"/> Genetic condition with developmental delay concern | <input type="checkbox"/> Global delay |
| <input type="checkbox"/> Prenatal exposure (substances / alcohol) | <input type="checkbox"/> Other: _____ |

Secondary neurodevelopmental concerns (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Communication issues | <input type="checkbox"/> Behavioral concerns |
| <input type="checkbox"/> Emotional / mental health concerns | <input type="checkbox"/> Social concerns |
| <input type="checkbox"/> Physical concerns | <input type="checkbox"/> Growth concerns |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Special condition (C P, spina bifida, etc.) |
| <input type="checkbox"/> Other: _____ | |

Attachments (check all attached):

- | | |
|--|--|
| <input type="checkbox"/> Well Child Check | <input type="checkbox"/> Vision Screening |
| <input type="checkbox"/> M-CHAT or ASQ | <input type="checkbox"/> Birth Record |
| <input type="checkbox"/> ESSR | <input type="checkbox"/> Behavioral Record |
| <input type="checkbox"/> IFSP | <input type="checkbox"/> Growth Chart |
| <input type="checkbox"/> Hearing Screening | <input type="checkbox"/> Other: _____ |

Additional information to consider for this referral:

Primary care medical provider: _____

Primary care provider has known this patient for: _____ (years / months)

Direct questions regarding this referral to: _____ at _____

Medical Provider Name: _____ **Provider NPI:** _____

Medical Provider Signature: _____ **Date:** _____

Fax completed form and attachments to Sue Armstrong: 800-466-1538

sue@alaskachd.org ♦ 907-264-6281 (phone)

PND Medical Referral FORM. Revised 05.2019