State of Alaska
Neurodevelopmental Outreach Clinic

Medical Provider Referral Form

Please print, fill out, and fax with attachments to the Clinic Coordinator 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):

___ Autism rule-out
___ Genetic condition with developmental delay concern
___ Prenatal exposure (substances / alcohol)
___ Autism follow-up
___ Global delay
___ Other: _____

Secondary neurodevelopmental concerns (check all that apply):

___ Communication issues
___ Emotional / mental health concerns
___ Physical concerns
___ Trauma
___ Other: _____
___ Behavioral concerns
___ Social concerns
___ Growth concerns
___ Special condition (C P, spina bifida, etc.)

Attachments (check all attached):

___ Well Child Check
___ M-CHAT or ASQ
___ ESSR
___ IFSP
___ Hearing Screening
___ Vision Screening
___ Birth Record
___ Behavioral Record
___ Growth Chart
___ 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 the Clinic Coordinator: Wahlira Tandjah, LMSW.
Fax: 800-466-1538 ♦ Email: autism@alaskachd.org ♦ Phone: 907-264-6281

 This referral will be kept active for two years after the date it is received.