State of Alaska Neurodevelopmental Outreach Clinic
Medical Provider Referral Form

Please print, fill out, and fax with attachments to: 907-754-3424

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

Secondary neurodevelopmental concerns/delays (check all that apply):

___ Communication/Speech
___ Emotional / Mental Health
___ Physical / Fine Motor
___ Trauma
___ Other:
___ Behavioral
___ Social
___ Growth
___ Co-occuring condition (CP, Spina Bifida, Down Syndrome, etc.):

Attachments (check all attached):

___ Well Child Check
___ ASQ
___ ESER, IFSP and/or IEP
___ MCHAT
___ Hearing Screening
___ Vision Screening
___ Birth Record
___ Behavioral Record
___ Growth Chart
___ Other (ADOS, STAT, etc.):

Additional information to consider for this referral, please include as much information as possible (parent/caregiver, childcare or school reports, observations, disciplinary actions. evaluations, etc):

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:** _____

Complete form and send attachments to the Clinic Coordinator: Haley Sanchez, MPH.
Fax: 907 754 3424 ♦ Email: neuro.clinic@alaska.gov ♦ Phone Number: 907-441-7792

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