Riley Hospital for Children
Indiana University Health

Consultation Request Form - Neurodevelopmental and Behavioral Center
Developmental Pediatrics/Child Development/Behavioral Pediatrics

To be used for non-urgent referrals only. For urgent concerns, please contact our office at 317-944-4846. Fax completed form along with the required documentation to 317-944-9760. Upon acceptance of the referral, we will make one attempt to call the family. If unable to reach the family, we will mail them a letter (with a copy to your office) asking them to contact us to schedule. We will notify you via fax if a referral is not accepted for any reason. We will notify you via fax when the patient is scheduled.

Required Documentation:

- Notes from the two most recent office visits pertaining to this issue
- Copy of front and back of patient's insurance card – not required if patient's primary insurance is Indiana Medicaid
- Growth Charts (length, weight and OFC)

Suggested Documentation:

To provide your patient with the most complete evaluation, please include the following documents with your referral if available:

- Birth records
- Results of recent hearing or vision screens
- Relevant lab or study results (Lead, CBC, chromosomes, MRI, etc.)
- Results of any developmental testing/screening that has been performed (ASQ, M-CHAT)
- Copy of most recent developmental or educational evaluation (First Steps IFSP, School IEP, Testing results)

Patient Information ***All fields must be complete and legible***

Today's Date:		IU Health MRN:	
Patient Name:			
Gender: ☐Male ☐Female	DOB:	Age:	Race/Ethnicity:
Patient's Address:			
City:	State:	Zip Code:	County:
Caregiver's Name:		Relationship to Patient:	
Primary Phone #:		Alternate Phone #:	

Insurance Information

Primary Insurance Company:	Policy/Member #:
Policy Holder Name:	Precertification Phone #:

Consultation Request (attach additional sheet if needed to provide adequate detail)

In order to help us identify the best service for your patient, please list any current diagnoses and provide a detailed description of the reason for the referral, including specific behaviors of concern and any diagnoses you would like to have evaluated.

If child is under 3, has an M-CHAT been done? ☐Yes ☐No	If child is under 5, has an ASQ been done? ☐Yes ☐ No
Does this patient require an interpreter? ☐Yes ☐No	If yes, language needed:
If you are requesting a specific provider, please indicate the name here:	

Referring Provider Information

Provider Name:	☐Primary Care Physician ☐Specialist:	
Office Phone Number:	Office Fax Number:	Contact Person:

You should receive a fax copy of our communication to the family within 3 to 5 business days of your referral.
If you have not heard from us within 5 business days, please call 317-944-4846 to confirm that your referral was received.