Outpatient Psychology Clinic

Referral Form

Children's Hospital
New Orleans
LCMC Health

Today's date: _____

Child's name: _____ Date of birth: _____

Legal guardian name: _____ Phone: _____

Referring provider: _____ Referring provider phone: _____

Reason for referral: _____

_____

_____

To route the referral to the most appropriate department, please select the **one** below that best applies and **answer** the corresponding question(s). **We do not offer evaluations for learning disorders.**

O **Autism Center**

For autism testing or a diagnostic evaluation: O Yes O No

The child has received a formal diagnosis of autism spectrum disorder: O Yes O No

O **Developmental Pediatrician** - for medication management and/or care coordination

O **Medical Psychology Clinic** (previously known as Rapid Treatment Program)

For the evaluation and treatment with medication management.

I agree to prescribe the medication after the patient is stabilized and discharged from the program.

Check those that apply: O ADHD O Anxiety O Depression

Date of last visit with primary care provider: _____

O **Psychology Evaluation**

Is this for therapy? O Yes O No

Are your requesting testing? O Yes O No

Is there a neurological diagnosis? O Yes O No

Please fax this completed form with the patient's demographics, insurance information, and a copy of the last clinic note from the primary care provider to 504.896.7273.

Phone: 504.896.7272
Fax: 504.896.7273