RALEIGH NEUROLOGY ASSOCIATES, P.A.

Developmental Pediatrics New Patient Appointment Request/Triage Sheet

Patient's Full Name:_____

Date of Birth:_____ Age:_____ Sex: M or F (circle one)

Parent(s) names: _____ _____

Mailing Address:_____

City: _____State:_____Zip Code:_____

Phone Numbers: (H):_____(C):_____(W)_____

Parent's Email Address:_____

Is an Interpreter needed for the family? YES or NO *Required Language:*_____

Parent/Guarantor Name:_____ Guarantor's DOB:_____

Insurance Company:_____

Insurance ID#:_____ Group #:_____

Insured's Name (if other than guarantor):_____ Insured's DOB:_____

If Medicaid, is it CAROLINA ACCESS? YES or NO Can authorization be used for testing also? YES or NO

Ins. Authorization/NPI#:_____ How Many Authorized Visits/Months?_____

In order to ensure the timeliest scheduling, if a patient has an HMO, Tricare Prime, or Cigna Connect, or other insurance plan requiring an authorization, please complete & include any necessary documentation with the referral.

Referring Provider's Name:_____

Practice Name/Address/Phone/Fax:_____

_____

_____

Name of Referral Coordinator & best contact number if we have a question about this referral?_____

_____

REFERRALS WILL NOT BE ACCEPTED WITHOUT THE COMPLETION OF ALL BELOW INFORMATION

Please indicate the reason for the referral-REQUIRED: (circle all that apply)

Developmental Delay	*ADHD*	*School Concerns*
Autism	*Behavioral Problems*	*Other:*___

If the reason for the referral is AUTISM, has the patient been evaluated or previously diagnosed? ☐ Yes ☐ No

Give a description of your referral concerns-please be specific:_____

_____

_____

Has the patient already been seen by Developmental Pediatrics or a psychiatrist for this same issue? ☐ Yes ☐ No

If yes, who have they previously seen? _____

Please fax this completed form along with demographics, insurance cards, all pertinent medical and/or school records, and recent office notes to 919-788-8986 Attn: Pediatric Dev Peds New Patient Appointments.

Any referrals received without requested information, including this form, will be returned to the referring office.

For Office Use Only:

Assigned Provider: _____ ☐Intake ☐ Quotient Testing ☐ Vanderbilts ☐ SNAP Parent ☐ SNAP Teacher ☐ Pediatric Symptom Checklist ☐ Other:_____

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