Request for Services to Center for Disabilities and Development

Patient Name: DOB:	UIHC MRN: ☐ Male ☐ Female

Date:		Relationship to Patient: ☐ Biological Parent ☐ Step Parent ☐ Foster Parent ☐ Guardian (must send guardianship papers)
Patient's Primary Custodian:		
Patient's Address:	Phone:	
Primary Insurance:	Policy Number:	Group Number:
Secondary Insurance:	Policy Number:	GroupNumber:

Clinical Question to be answered:

Discipline/Service:

☐ **Physical Therapy:**
- ☐ Evaluation
  - ☐ Gross Motor/Mobility
  - ☐ Lower Extremity Bracing
  - ☐ Torticollis
- ☐ Therapy

☐ **Audiology:**
- ☐ Hearing Evaluation
- ☐ Unsedated ABR

☐ **Occupational Therapy:**
- ☐ Evaluation
  - ☐ Fine Motor/Handwriting
  - ☐ Sensory (will coordinate with Medical)
  - ☐ Activities of Daily Living
- ☐ Therapy

☐ **Equipment (PT/OT):**
- ☐ Wheelchair
- ☐ Stander
- ☐ Car Seat
- ☐ Gait Trainer
- ☐ Walker

☐ **Autism:**
- ☐ Diagnosis (screener will be sent to family)
- ☐ 2nd Opinion Diagnosis
- ☐ Establish Care/ Medication Management

☐ **Educational Evaluation**
- ☐ Reading Disorder/Dyslexia
- ☐ Writing Disorder/Dysgraphia
- ☐ Math Disorder/Dyscalculia

☐ **Speech Pathology:**
- ☐ Evaluation
  - ☐ Speech/Articulation
  - ☐ Augmentative Communication
  - ☐ Language
  - ☐ Feeding
- ☐ Therapy

☐ **Psychology:**
- ☐ Cognitive Evaluation
- ☐ ID Waiver
- ☐ Neuro-psychology testing
- ☐ Challenging Behavior Day Treatment Program
- ☐ Challenging Behavior Clinic

☐ **Medical:**
- ☐ ADHD/ADD
- ☐ Developmental Evaluation
- ☐ Medication Management
- ☐ Neuromotor-36+ months (will coordinate with PT)
- ☐ Sleep Clinic
- ☐ Adult/Adolescent Neurodevelopmental (CP, Spina Bifida, ID, Autism)- >12 years

☐ **Neuro Developmental Evaluation:**
- ☐ Less than 18 Months (Medical & PT)
- ☐ Birth-36 Months (Medical, PT, OT, Speech, Social Work, Audiology)
- ☐ With Nutrition

☐ **Social Work**
- ☐ Transition Clinic (Social Work & Employment)
- ☐ Therapy
  - ☐ PCIT
  - ☐ ImPACT
  - ☐ Incredible Years Group
- ☐ Service Consultation

Is an interpreter needed? ☐ yes ☐ no If yes, please specify language:_____

Referring provider–Name:_____ Phone:_____

Address:_____ FAX:_____

Please FAX this **form**, all **medical records**, and **guardianship** information to 319-384-9393.

We will not schedule until the documents have been received.

If you have questions, please call 319-353-6900.

University of Iowa Stead Family Children's Hospital