Center For Disabilities and Development- Request for Services

TO REFER A PATIENT THE FOLLOWING STEPS ARE REQUIRED:

1. Fax this form, a face sheet, all pertinent medical records, and guardianship information to 319-384-9393

2. Call our schedulers at 319-353-6900 Option 1, then option 2 to open a referral shell with our clinic. *A packet will be mailed to the patient. The patient will not be scheduled until the packet has been received along with proof of adoption/court orders if applicable*.*

IOWA HEALTH CARE

Updated 05/09/2024

Patient Name:		**Date:**	☐ **Male** ☐ **Female** ☐ **Other** _____
DOB:	**Preferred Language:**	**Interpreter Needed?**	
Patient's Primary Custodian:			**Relationship to Patient:** ☐ **Biological Parent** ☐ **Adoptive Parent*** ☐ **Guardian**** ☐ **Foster Parent****
Patient's Address:			
City, State, & Zip:	**Phone:**		
Primary Insurance:	**Group Number:**		**Policy Number:**

REQUIRED- Please list concerns to be addressed at the CDD: (DO NOT List ICD-10 code):

DISCIPLINE/SERVICE: PLEASE CHECK BOXES OF SERVICES NEEDED.

☐ **ADHD:**
- ☐ Diagnosis
- ☐ Recommendation/Initiation of Medication

☐ **Audiology**:
- ☐ Hearing Evaluation
- ☐ Non-sedated ABR

☐ **Autism:**
- ☐ Diagnosis
- ☐ Recommendation/Initiation of Medication

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

☐ **Equipment OT/PT:**
- ☐Bath Chair
- ☐Car Seat
- ☐Gait Trainer
- ☐Safety Bed
- ☐Stander
- ☐Walker
- ☐Wheelchair

☐ **Intellectual Disability/ID Waiver Assessment**

☐ **Neuromotor Clinic-(36 Months and up)** Unexplained motor delays, cerebral palsy, down syndrome, spina bifida, myotonic dystrophy, hypotonia.

☐ **Occupational Therapy:**
- ☐Activities of Daily Living
- ☐Developmental Delay (5 and under)
- ☐Fine Motor
- ☐ Sensory

☐ **Physical Therapy:**
- ☐Developmental Delay (5 and under)
- ☐ Gross Motor/Mobility
- ☐ Lower Extremity Bracing
- ☐ Torticollis

☐ **Speech-Language Pathology:**
- ☐ Augmentative Communication
- ☐Developmental Delay (5 and under)
- ☐ Language

☐ **Social Work:**
- ☐ Transition Clinic (Social work and employment specialist)
- ☐ Service Consultation

Referring Office Name :_____

Referring Provider Name:_____

Address:_____

_____

Fax: _____ **Phone:**_____

***Our service goal is to return your patient to their medical home, including medication management.**

*** A court-ordered adoption decree or amended birth certificate required if patient was seen at UIHC prior to being adopted.**

**** If patient is under a court-ordered guardianship, the court-ordered guardianship document is required to be faxed at the time of referral.**