



OLSON HUFF CENTER FOR CHILD DEVELOPMENT
 11 Vanderbilt Park Drive, Asheville, NC 28803
 Phone: (828) 213-1780 (800) 377-9251
 Fax: (828) 213-1785

PLEASE COMPLETE ENTIRE FORM AND FAX TO 213-1785

Referral does not guarantee appointment. Please allow **10 business days** for appointments to be reviewed and scheduled.

Adrian Sandler, MD Victoria Sheppard-LaBreque, MD Melissa Thingvoll MD
Koren Boggs, PhD Mary Alice Girardi, NP Scott W. Governo, NP
Darren S. Boice, LCSW Melissa Lillie, LCSW Shaaron Boyles, LCSW

Patients Name: _____ DOB: _____ Age: _____
 (First) (MI) (Last)

Mailing Address: _____, _____, _____
 (Street-PO Box) (City) (State) (Zip)

Mother's Name: _____ Father's Name: _____
 (Guardian) (First) (Last) (Guardian) (First) (Last)

Home Phone: (____) _____ Mother's Cell Phone: (____) _____ Mother's Work Phone: (____) _____

Father's Cell Phone: (____) _____ Father's Work Phone: (____) _____

Name of Other Contact _____ Other Contact Phone Number: _____ Relationship: _____

Referring Healthcare Provider: _____

Mailing Address: _____, _____, _____
 (Street-PO Box) (City) (State) (Zip)

Office Phone: (____) _____ Office Fax: (____) _____

Primary Care Physician (if other than referring): _____

GUARDIANS MUST BRING PROOF OF GUARDIANSHIP TO THE APPOINTMENT

Name of Insurance: _____ Medicaid/Carolina Access Referral Number: _____

NPI Number: _____

*****PLEASE SEND INSURANCE CARD COPY (FRONT & BACK)*****

Is an interpreter needed? YES NO - If yes, language _____

TO BE COMPLETED BY THE REFERRING PROVIDER ONLY

Referring Concern _____

If referral is specifically for psychopharm consult in child with established autism spectrum diagnosis, check here _____

What other providers has this child seen for this concern or diagnosis?

Established or suspected diagnosis: _____

Previous Psychoactive Medications: _____

Current Medications _____

Previous Psychiatric Evaluation? Yes No Previous Psychiatric Hospitalizations? Yes No

History of Abuse? Yes No History of Suicide or Self Harm? Yes No

Please rate urgency of your referral (Circle One)

Routine Semi - Urgent Urgent (and if so why?)

Disposition

Appointment date: _____ Referred to other agency: _____ Unable to reach patient: _____

COMMENTS: _____

Signature: _____

Date: _____