Psychiatry Referral Form

Central Scheduling
PH: 937-641-4000 Fax: 937-641-4500 Toll Free Fax: 866-891-6941
One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request: _____

PATIENT INFORMATION

Patient's Name: _____
❑ M ❑ F DOB: _____
Parent/Guardian Name(s): _____
Home Phone: _____
Cell Phone: _____ Work Phone _____
Email address: _____
Preferred Contact Phone: ❑ Work ❑ Cell ❑ Home
Do you need an interpreter? _____
Patient is in custody of: ❑ Parents ❑ Guardian ❑ CSB
Address: _____
City: _____ State _____ Zip _____
1st Insurance: _____ ID# _____
Precert # _____
2nd Insurance: _____ ID# _____
Precert # _____

REQUESTING PROVIDER GROUP:

Office name _____
Provider name _____
Office location _____
Office contact person _____
Phone _____ Fax _____
Signature _____

Our goal is to process referrals within two business days.
If unable to contact family within one week,
we will notify your office.

****If it is medically necessary for this patient to be seen urgently by a physician, call the department directly. ****

REASON FOR REQUEST

Diagnosis Code/Reason for referral: _____

Has this child been diagnosed with autism or significant developmental delay? ❑ Yes ❑ No

Does this child have any chronic medical conditions? If so, please list. ❑ Yes ❑ No

_____

_____

_____

Has this child been trialed on psychotropic medications? If so, please list. ❑ Yes ❑ No

_____

_____

_____

Has this child been psychiatrically hospitalized? ❑ Yes ❑ No

Date of hospitalization: _____ Location of hospitalization, if not Dayton Children's: _____

(PLEASE include ALL applicable clinical documentation to assist in triaging appointments.)