Blank Children's Hospital
UnityPoint Health

**Pediatric Psychology Referrals**
4055 Westown Parkway
West Des Moines, IA 50266
Office: (515) 224-3399
Fax: (515) 241-3290
unitypoint.org

**Date:** _____

**ATTENTION: PLEASE ATTACH SPECIFIC DETAILS AND/OR RECORDS REGARDING THE CHILD'S SYMPTOMS/CONCERNS OR THE REFERRAL MAY BE RETURNED**

**Reason for Referral:**

☐ Autism Testing

☐ Intellectual Disability (ID) Testing

☐ One-time behavioral consult for a child with autism, ID, and/or global developmental delay

- What specific behavior and when/where is it happening (e.g., child is aggressive during morning routine)?:_____

**Please list specific concerns for this child (this section must be completed):**

_____

_____

_____

## Symptoms/Concerns (check all that apply):

**Autism-related concerns? Yes / No**

☐ Peer difficulties

☐ Limited social communication (e.g., back-and-forth interaction)

☐ Repetitive behaviors/ intensive interests

**Other concerns? Yes / No**

☐ Intellectual disability

☐ Developmental delay

☐ Speech/Language

☐ Attention/Hyperactivity

☐ Aggression

☐ Self-injurious behavior

☐ Mood lability (e.g., irritability)

☐ Anxiety/Fears

☐ In utero substance exposure

☐ Tics/OCD

☐ Other: _____

**PATIENT:** _____ **DOB:** _____ **M** ☐ **F** ☐
(First) (MI) (Last)

**ADDRESS:** _____

**PRIMARY PHONE NUMBER:** _____

**Parent/Guardian:** Name: _____ DOB: _____
(W) _____ (Cell) _____

**Parent/Guardian:** Name: _____ DOB: _____
(W) _____ (Cell) _____

**INSURANCE INFORMATION: Please include copy of front and back of insurance card(s)**

Primary Insurance: _____ Subscriber: _____ DOB: _____
Group #: _____ Policy #: _____

Secondary Insurance: _____ Subscriber: _____ DOB: _____
Group #: _____ Policy #: _____

Medicaid #: _____ Assigned MCO: _____

**REFERRING PHYSICIAN**: _____

Address: _____ Phone: _____ Fax: _____

**INTERPRETER NEEDED?** YES ☐ NO ☐ Preferred Language: _____