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DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS CONSULTATION REQUEST FORM

Completed by UNC PN -Provider ONLY

Patient Information

Last Name: _____ First Name: _____ Middle _____

UNC Medical Record Number _____ Patient DOB: ____/____/____ Today's Date: ____/____/___

Referring Physician or Provider: _____ NPI _____

Practice Site: _____ Referral Contact person:_____ Phone:_____

Please complete ALL fields

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Reason for Referral

Please describe briefly the reason for referral: (If details are in progress note please note that and provide date of encounter)

_____

_____

_____

I am aware of the Consultation ONLY policy and discussed with patient and/or family _____ (Provider please initial)

Patient signed release of information between UNC and CDP and is included with referral _____ (PCP or Staff please initial)

Please fax this completed form AND release of information to (919) 362-5409.
Thank you for your time and referral.

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Office Use only
Date rec'd: _____ MD reviewed _____ Documents complete _____ Accept _____
Notes: