

PARENT-CHILD SERVICES GROUP, INC. & THE READ CENTER
ONLINE REFERRAL FORM

Child's Name: _____ Birth Date: _____ Age: _____

Parent's Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ Zip Code: _____

REASON FOR REFERRAL (Mark all that apply to your concerns. A phone interview will be conducted to finalize appointments and confirm associated costs.):

Appointments with a Speech-Language Pathologist:

All evaluations include formal and informal measures that may address the following areas (depending on age and concerns) plus a hearing screening and oral examination to evaluate oral/motor functioning. Please mark major areas of concern:

- | | |
|--|--|
| <input type="checkbox"/> Speech / Articulation | <input type="checkbox"/> Voice |
| <input type="checkbox"/> Language / Auditory Processing | <input type="checkbox"/> Fast ForWord - Programs for Auditory Processing |
| <input type="checkbox"/> Fluency | <input type="checkbox"/> Pragmatics / Social Communication |
| <input type="checkbox"/> Reading / Written Language / Spelling | <input type="checkbox"/> Oral Motor / Feeding Skills |

Appointments with an Occupational Therapist:

OT - Includes evaluations of motor function for small muscles such as in the hands, arms, and upper body, and sensory processing. Additionally, the evaluation may include measures of handwriting function, visual-perceptual skills, and activities of daily living/self help.

Appointments with a Physical Therapist:

PT - Includes evaluations of motor function for large muscles such as those used for walking, sitting, and overall balance.

Appointments with the Psychologist:

Developmental Screening - Includes a screening measure of the child's general cognitive level as well as a review of various areas of development. A parent consult is included.

Psycho-Educational Evaluation - Includes complete intellectual testing, academic testing, basic visual and auditory processing scales, and checklists as needed to determine attentional or behavioral factors. A parent consult and summary report is included.

Psychological Evaluation - Includes tests of emotional development as well as tests of cognitive/intellectual functioning and educational functioning. A parent consult and summary report is included.

Appointments with the Psychiatrist:

- Medical** - Includes medical consultation, a summary report, and a follow-up for medication as needed.

Appointments for the Behavior Analyst:

Includes a consultation to review behavioral therapy options (at no cost), a scheduled evaluation of behavioral/developmental concerns, and a summary report.

Appointments for the Reading Specialist/Tutor:

Includes an initial evaluation/consultation to review academic problem areas and design a personalized program.

Appointments for a Team Evaluation:

Team evaluations include evaluations by the psychologist, speech-language pathologist, occupational therapist, physical therapist, reading specialist, and/or the psychiatrist with an integrated report and parent consultation.

Comments / Concerns: _____

Child's Name: _____

Date: _____

Child's Current School / Grade: _____

Child's Physician: _____

Other Professionals / Physicians currently seeing the child: _____

What previous services / evaluations has the child received? _____

Insurance Company: _____ Plan to submit charges? Yes No

Who referred to PCSG?: _____

Title/Specialty of referral source: _____

Address of referral source: _____ Zip: _____

Phone number of referral source _____

Preferred days / times for scheduling appointment: _____

PLEASE FAX TO 865-584-6607. Our office personnel will call to clarify any questions, send information, or schedule an appointment. A completed copy of the online child history form and copies of reports from other agencies or service providers must be received prior to your appointment.

FOR OFFICE USE ONLY:

Received Date: _____

Intake By: _____ Date: _____

ACTION REQUIRED: Schedule Appt.: _____ at _____ with _____

Schedule Appt.: _____ at _____ with _____

Schedule Appt.: _____ at _____ with _____

Schedule Appt.: _____ at _____ with _____

cc: Therapist
Main File

Send Info Packet: Yes No FF Info: Yes No
Call: _____

Notes: _____