State of Alaska

Pediatric Neurodevelopmental Outreach and Autism Screening Clinic

Medical Provider Referral Form

Patient's Name____ Patient's DOB_____________ M / F

Parent Name and contact information: ____

Patient's Home Region: Nome /Homer/Dillingham /Bethel / FBKS /Barrow/ Kotzebue / Ketchikan / Juneau/Kodiak/Mat-Su

Primary reason for neurodevelopmental referral (check one)

	Autism rule-out		**Autism follow-up**
	Global Delay		**Genetic condition w/developmental delay concern**
			Other:

Secondary neurodevelopmental concerns (check all that apply)

	Communication issues		**Behavioral concerns**
	Emotional/mental health concerns		**Social concerns**
	Physical concerns		**Growth concerns**
	Other:		**Special condition (CP, spina bifida, etc.)**

Please attach patient medical record: Well Child Checks, MCHAT or ASQ results, other assessments

Any additional information to consider for this referral?

Primary care medical provider: ____

Primary care provider has known this patient for _____________________________ (years / months)

Direct questions regarding this referral to___________________________ at ____________________

Medical Provider Name: ______________________________________ **Provider NPI:** _____________

Medical Provider Signature: ___________________________________ **Date:** ____________________

Fax completed form **to Meghan Clark – (907) 754-3424 or (907) 269-3432 (fax)** meghan.clark@alaska.gov ♦ **(907) 269-3428**