1001 w. williams st.
suite 104
apex, nc 27502

p 919.362.5406
f 919.362.5409

www.cdpeds.com

DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS CONSULTATION REQUEST FORM

Completed by UNC PN -Provider

Patient Information

Last Name: _______________________ First Name: _____________________ Middle ________ Phone: ____________

Address: ____ Insurance :_____________________________

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

Referring Physician Information

Referring Physician or Provider: ____ NPI _________________________________

Practice Name/Location: ____________________________________ Referral Contact person:_________________________

Physician Phone:___________________________ Fax: _________________________

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:

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ UNC MR # ______________

I request and authorize **UNC Healthcare** ______________________ to release healthcare information of the patient named above to:

Name: **Carolina Developmental Pediatrics**

Address: 1001 W. Williams St. Ste 104

City: Apex State: NC Zip Code: 27502

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________

____

☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Parent Signature: ______________________ Date Signed: ______________

Parent Name (Printed) ____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Fax completed form to :

919-362-5409