UNC
CAROLINA INSTITUTE FOR
DEVELOPMENTAL DISABILITIES

101 RENEE LYNNE CT.
CARRBORO NC, 27510

T 919-966-5171
F 919-966-2230
www.cidd.unc.edu

Today's Date _____

Person completing the Clinical Referral Form:

☐ Medical, mental health/behavioral health, educational professional, or therapist
☐ Parent, legal guardian, or other caregiver
☐ Self

Has this client/family member been seen at UNCH Hospitals/UNC Healthcare for any reason before?

☐ Yes ☐ No ☐ Unknown

UNCH Medical Record Number: _____ ☐ Unknown

CLIENT / FAMILY INFORMATION:

Client / Patient: _____ **Age:** _____ **Date of Birth:** _____

Nickname: _____ **Gender:** ☐ Female ☐ Male

Grade in School: _____ **Home Schooled:** ☐ Yes ☐ No

Name of PRIMARY CONTACT/Caregiver for Client: _____

Relationship to Client: ☐ Parent ☐ Self ☐ Guardian ☐ Other: _____

Mailing Address: _____
Street Address

_____ _____ _____
City State Zip Code

Contact Information: ( ) – _____ ( ) – _____
(Home) (Cell)
( ) – _____ _____
(Work) email

Name of Legal Guardian, if different from Primary Contact: _____

Name of GUARANTOR (person responsible for payment): _____

Guarantor's Date of Birth: _____ ☐ Address same as client/patient

Mailing Address: _____
Street Address

_____ _____ _____
City State Zip Code

PRIMARY INSURANCE PROVIDER: _____

SECONDARY INSURANCE PROVIDER: _____

Name of PRIMARY CARE PROVIDER *(If applicable)*: _____

REFERRING PROFESSIONAL (*If applicable)*: **Name:** _____

Discipline: ☐ Medicine ☐ Mental Health ☐ Educational Professional
☐ Allied Health Professional ☐ Other: _____

Practice, Agency, or School Name: _____

_____
Street Address

_____ _____ _____
City State Zip Code

( ) – Ext: ( ) –
Phone Fax

Will the patient need any special accommodations? *(For example, needs interpreter for the deaf, translator for another language, fearful of leaving parent, etc.)*

☐ **Yes** Explain: _____

What is the primary language spoken in the home: _____ **by your child?**_____

1) Is the client/family member being referred by a professional for a consultation with a particular discipline or specific professional at the CIDD?

☐ **Yes** Please list the specific discipline(s) (*e.g., speech therapy, psychology, etc.*) and/or professional(s):

_____

☐ **No** / **I don't know**

2) Has your client/family member ever had any of the following educational assistance plans?
(*Check ✓ all that apply)*

☐ Individualized Education Plan (IEP) ☐ 504 Plan ☐ Individual Family Service Plan ☐ Other

3) Is your client/family member involved in any of the following therapies or treatments?
(*Check ✓ all that apply)*

☐ Speech-Language Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ Mental Health / Counseling ☐ Psychiatric Medication Treatment ☐ Early Intervention
☐ Special Education Services ☐ Home-Based Behavioral Services ☐ Other

4) Does your client/family member have a previous developmental, medical, psychiatric, or learning disability diagnosis?

☐ **Yes** Please complete the table below to the best of your ability:

Diagnosis	**Approximate Date of Diagnosis**	**Professional Disciplines Making the Diagnosis**	**Name of Professional (*or Agency if known*)**

☐ **No** ☐ **I don't know**

5) Has your client/family member ever had any cognitive (also known as Intellectual or "IQ") testing?

☐ **Yes** Please complete the table below to the best of your ability:

Type of Test (*if known*)	**Approximate Date of Testing**	**Composite Test Score**	**School Based or Non-School Based Assessment**
			☐ School ☐ Other
			☐ School ☐ Other
			☐ School ☐ Other

☐ **No** ☐ **I don't know**

6) Please describe your concerns regarding your client/family member in the following areas below:

Please include as much information as possible, as this information is used to determine appropriate services at the CIDD.

AREA OF CONCERN:	DESCRIPTION OF YOUR CONCERNS:
Behavioral and/or Emotional Concerns: (e.g., anger; depression; activity level)	
Learning Difficulties/ Challenges: (e.g., reading; memory; writing processing)	
Speech-Language or Communication Concerns: (e.g., understanding what is said; talking)	
Social Development Concerns: (e.g., making friends)	
Motor/Movement Concerns: (e.g., walking; balance; gross & fine motor skills)	
Medical Concerns: (e.g., seizures; genetic disorders; medications)	
Other / What are the main questions you hope to have answered by an evaluation or consultation at the CIDD?	

7) Is assessment for an Autism Spectrum Disorder (Autistic Disorder; PDD NOS; Asperger's Disorder, High Functioning Autism) an important question for you regarding your client/family member?

☐ **Yes** ☐ **No** ☐ **I don't know**

8) Are you seeking treatment for an Autism Spectrum Disorder (Autistic Disorder; PDD NOS; Asperger's Disorder, High Functioning Autism)?

☐ **Yes** ☐ **No** ☐ **I don't know**

9) Are you seeking treatment or therapy for another developmental disability?

☐ **Yes** ☐ **No** ☐ **I don't know**

10) Are you seeking a behavior management plan?

☐ **Yes** ☐ **No** ☐ **I don't know**

11) Are you seeking medication management?

☐ **Yes** ☐ **No** ☐ **I don't know**

12) Are you seeking IQ and/or achievement testing?

☐ **Yes** ☐ **No** ☐ **I don't know**

This completed form may be faxed to 919-966-2230 or mailed to 101 Renee Lynne Ct. Carrboro, NC 27510

Please Note:

At this time, our center offers clinical evaluations that target individuals whose previous assessments and/or services in their local area have not fully enhanced their learning, development, and/or treatment. If you have not pursued assessment in your local area, please be aware that the CIDD may suggest that you do so. Due to the nature of our services, we have limited appointment availability and variable waiting lists for our services. Depending upon a person's needs, evaluation services may be provided by individual clinicians, small teams of 2 or 3 clinicians, or a full interdisciplinary team. This form will be reviewed by our clinical staff to determine the disciplines to include in the evaluation. We will contact you as soon as this form is reviewed. Thanks in advance for your patience!