# UNC Beacon Program Child Evaluation Clinic

(984) 974-0470

**Medical Provider Referral Form**

**PLEASE FAX TO 984-974-0875**
**IF THERE ARE QUESTIONS, PLEASE CALL BEACON AT 984-974-0470.**
**THIS FORM MUST BE COMPLETED PRIOR TO SCHEDULING AN APPOINTMENT**

## Referral Source:

Name: _____

Agency: _____

Address:_____

_____

Office phone: _____

Fax: _____

Email address: _____

## Case Information:

Child's name: _____

DOB: _____ Gender: _____ Race: _____

Social Security Number: _____

Child's current address: _____

_____

_____

Phone number (s): _____

Household members (include age and relationship to child):

_____

_____

_____

_____

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**Concerns for maltreatment (check all that apply):**

☐ sexual abuse ☐ physical abuse ☐ neglect ☐ emotional abuse

☐ other: _____

IF APPLICABLE: Date Incident Occurred: _____

**** If <72 hours please contact Beacon CPT person on call & do not schedule for an appointment. Call UNC Hospital Operator at 984-974-1000 to speak to the Beacon on call provider. During daytime hours the Beacon office can assist with contact 984-974-0470.**

Please summarize concerns: _____

_____

_____

_____

_____

_____

Was a report made to Child Protective Services or law enforcement?

☐Yes ☐No

Agency: _____

Contact: _____

Report date: _____

Has the child had a medical exam prior to appointment?

☐Yes ☐No

*If this was a medical exam for concerns of maltreatment,* ***please forward a copy of the medical record for the appointment (fax: 984-974-0875).***

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**Special Circumstances for Child:**

Developmental Delays ☐Yes ☐No _____
(such as speech delays/motor delays/cognitive delays)

Foreign language: ☐Yes ☐No _____

Interpreter needed for child? ☐Yes ☐No _____(language)

Interpreter needed for parent? ☐Yes ☐No _____(language)

**Family Information:**

PARENT NAMES AND DATES OF BIRTH **(required for at least one parent):**

Mother: _____DOB:_____

Father:_____ DOB:_____

Please provide contact information for child's parents if they are not the current caregivers.

Address: _____

_____

County: _____ Phone: _____

Reason not living with parents: _____

_____

**Method of Payment:**

Medicaid:_____ (provide number)

Other: (i.e.: private insurance, victims crime fund, self-pay):_____

_____

Primary Care Physician (PCP): _____

Contact Information:_____