OLSON HUFF CENTER FOR CHILD DEVELOPMENT
11 Vanderbilt Park Drive, Asheville, NC 28803
Phone: (828) 213-1780 or (800) 377-9251 Fax: (828) 213-1785
PLEASE COMPLETE ENTIRE FORM AND FAX TO 213-1785

Patient Name: _____ _____ _____ DOB: _____ Age: _____
(First) (MI) (Last)

Mailing Address: _____, _____, _____, _____
(Street – PO Box) (City) (State) (Zip)

Mother's Name: _____ _____ Father's Name: _____ _____
(Guardian) (First) (Last) (Guardian) (First) (Last)

Home Phone: (____) _____ Mother's Cell Phone: (_____) _____ Mother's Work Phone (___) _____

Father's Cell Phone: (_____) _____ Father's Work Phone: (___) _____

Name of Other Contact: _____ Phone Number: _____ Relationship: _____

Referring Healthcare Provider: _____

Office Mailing Address: _____, _____, _____, _____
(Street – PO Box) (City) (State) (Zip)

Office Phone: (_____) _____ Office Fax: (_____) _____

Primary Care Physician (if other than referring): _____

Name of Insurance: _____ Medicaid/Carolina Access Referral Number: _____

Is an interpreter needed? YES☐ NO☐ If yes, language _____NPI Number: _____

Is the primary concern for referral a developmental issue/delay/disability? ( ) Yes ( ) No ( ) Not sure

Reason for Referral:_____

In order to help us process this referral please check any of the following concerns that apply:

_____**1. Parent requested eval at OHC**

_____**2. Autism (ASD) previously diagnosed, need second opinion re diagnosis**

_____**3. ASD previously diagnosed, need help with management**

_____**4. ASD suspected, need diagnostic evaluation**

_____**5. ASD unlikely, rule out ASD**

_____**6. Behavior/parenting problems**

_____**7. ADHD suspected, need diagnostic evaluation**

_____**8. Complex ADHD (comorbid diagnoses suspected/confirmed)**

_____**9. Primary psychiatric disorder (depression, bipolar disorder, etc.)**

DISPOSITION

Appointment date: _____ Referred to other agency: _____ Unable to reach patient _____

COMMENTS: _____

Signature: _____ Date: _____ Rev. 10/15