UC San Diego
SCHOOL OF MEDICINE

THE DEVELOPMENTAL-BEHAVIORAL PEDIATRICS CLINIC

7910 Frost Street, Suite 280 San Diego, California 92123

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Dear Parent/Caregiver:

The following steps outline the process to obtain an appointment and help prepare for your visit to UCSD Developmental-Behavioral Pediatrics.

❶ **Primary Care Physician (PCP) or referring provider faxes a referral to 858-496-9257.**
The form is included in this packet for you to give to your PCP to complete, however check with your PCP to see if they have already started the referral process. The referral form from your PCP must include the patient's diagnosis code(s).

❷ **Insurance Authorization** –For an appointment to be scheduled for your consultation, we must have authorization from your insurance or your agreement to self-pay. You will be responsible for any co-pay, deductible or self-payment at the time of your visit.

❸ **Scheduling** – Our staff will contact you to schedule your visit.

❹ **Child Registration Form** and **Questionnaires**
Ask your child's teacher (or teachers, if they have multiple teachers) to complete the **School Questionnaire**. If your child is not in school, a babysitter, daycare provider, camp counselor, tutor, behavior or developmental therapist (speech, occupational, physical) etc. may fill out the school questionnaire instead. **Parents must complete the New patient forms within two weeks of scheduling your appointment.**

❺ **All questionnaires must be complete and received by the Developmental Behavioral Pediatrics office within 2 weeks of scheduling your appointment to avoid cancellation or rescheduling.**
COMPLETED forms may be sent to Developmental-Behavioral Pediatrics in one of 4 ways:

Via U.S. Mail: **UCSD Developmental Behavioral Pediatrics**
7910 Frost St.
Suite 280
San Diego, CA 92123

Via Fax: **(858) 496-9257**

Drop Off at The Clinic: **UCSD Developmental Behavioral Pediatrics**
Same address as above

Upload via My Chart https://mychartatradychildrens.org
Please initiate an advice question to the provider your child is scheduled to see.
The document can then be attached.

❻ You may provide **additional documentation** that you feel would be helpful for your child's evaluation, such as:

- School documents, such as IEPs and School Assessments
- Evaluations done at other medical facilities (e.g., neurology, genetics, etc.)
- Evaluations done at nonmedical facilities such as California Early Start, Regional Center, First 5
- Lab tests or imaging studies done outside of Rady Children's Hospital
- Therapist/Counselor Notes or a letter from the therapist/counselor, if your child has seen one.

Please call (858) 496-4860 if you have any questions

We look forward to serving your family!

Developmental-Behavioral Pediatrics Clinic
7910 Frost Street Suite 280 San Diego, CA 92123
Yi Hui Liu, MD, MPH ▪ Adam Braddock, MD
Theodora Nelson, MD ▪ Carolyn Sawyer, MD ▪ Lauren Gist, MD

Consultation Request Form **Fax completed form and supplemental information to 858-496-9257**

Patient Information:

Child's Name:_______________________________________Date of Birth: / / Age: _Gender: ☐ M ☐ F ☐Other

Caregiver's Name:____

Relation: ☐ Parent ☐ Foster Parent ☐ Other:____

Will an interpreter be needed? ☐ No ☐ Yes Which Language? ____

Mailing Address: ____

City: ____State: _________ZIP: _____________

Home: ( ) ______________Alt: ( ) _______________Email: ____

In order to schedule an appointment, an insurance authorization must be in place. Please check if family plans to self-pay:
__________Authorization required: ______YES ______NO

Insurance Carrier/Type: ____

Subscriber Name: ____Subscriber ID: ______________________

*Please have your staff request an authorization for **ALL** of the following CPT codes, a level 5 consultation visit (99245), developmental screening (96110), developmental testing (96112, 96113 X 3), behavioral assessment (96127 X 4), follow-up visits (99215x4, 99214x4, 99213x4), prolonged service with direct patient contact (99354), and additional time (99417x4).*

Referring Provider/Primary Care Physician:

Referring Provider Name: __________________________________Clinic Name: __________________________

Phone number: __________________________________Fax number for reports: __________________________

REQUIRED: Please describe in detail the primary reason for this consultation: ______________________
____
____

** For concerns of atypical development or learning problems, please ensure that referrals for appropriate concurrent services have also been submitted (e.g., school IEP request, speech therapy, etc.). **

Consultation requested for: ☐ diagnosis ☐ 2nd opinion ☐ medical workup ☐ medication management ☐ recommendations for services/resources

Diagnosis: ☐ Expressive language delay – F80.1 ☐ Receptive language delay or expressive and receptive language delay – F80.2 ☐ Gross motor delay – F82 ☐ Fine motor delay – F82 ☐ Social delay – F88 ☐ ADHD-inattentive – F90.0 ☐ Inattention R41.840 – Attention and concentration deficit ☐ Impulsiveness– R45.87 ☐ Hyperkinetic behavior – F90.9 ☐ ADHD-hyperactive/impulsive or combined type – F90.1 F90.2 ☐ Autism Spectrum Disorder – F84.0 ☐ Anxiety – F41.9 ☐ Depression – F32.9 ☐ Learning difficulties – F81.9 ☐ Academic underachievement – Z55.3 ☐ Oppositional behaviors/ODD – F91.3 ☐ Intellectual disability – F79 ☐ Feeding problems – R63.3 ☐ Sleep problems – G47.9

Is the patient currently under the care of a psychiatrist? ☐ Yes (If yes, please provide contact information and records)
☐ No

Other concerns with documented Dx code: ____
____
____

REQUIRED: Dx codes must be documented in EPIC referrals and on hard copy request.

***Note:** We do not evaluate children with complex or emergency mental health needs, or those taking multiple psychotropic medications. **Max age for new patients is 14 years old**. We do not provide comprehensive psychological testing, ongoing behavioral therapy, or ongoing mental health counseling.*

____ ______________________

Primary Care Physician's or Referring Provider's signature and specialty ***Date***

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Developmental-Behavioral Pediatrics
Child Registration Form

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Child's Name:	**Sex: M F Other:**	**Date of Birth:**
Child's Mailing Address:	City:	State/ZIP:
Home Phone, with area code: ( )	Child's Insurance:	
Child's Social Security Number:	Child's Race/Ethnicity:	

Child's Legal Guardian (please circle): Mother Father Both Other (specify):

Mother's Name:	**Date of Birth:**	**Home Phone: ( )**
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

Father's Name:	Date of Birth:	Home Phone: ( )
Marital Status: S M W D Sep	If remarried, spouse's name:	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

If there is another guardian other than the parents of this child, please complete guardian information below:

Guardian's Name:	Date of Birth:	Home Phone: ( )
Relationship to child:	Marital Status: S M W D Sep	
Street Address:	City:	State/ZIP:
If applicable: Occupation:	Employer:	
Work Phone: ( )	Cell/Pager: ( )	

PARENTS: Before we can evaluate your child, we need to collect information from your child's medical records, school, and other professionals involved in your child's care. We need your permission to do this. Please sign below.

MEDICAL RECORDS: Authorization is hereby granted for release of any information between professionals who are evaluating and treating my child, including other physicians, psychologists, counselors, and school personnel. This authorization includes release of results of psychoeducational testing, evaluations for grades, report cards, IEPs, and impressions. A copy of this authorization is as valid as the original up to 24 months from the date below.

Signature____Date_____________________

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Dear Parents,

Effective January 3rd, 2022 we will be enforcing a fee for appointments not cancelled 48 hours in advance and missed appointments.

New patients will be charged $50.00 and returning patients will be charged $25.00.

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Parent/Guardian Signature