



Dear Practitioner,

As part of our evaluation policy, we require referral documentation from a child's physician or treating practitioner. Please fax this completed form to our office so we may add this child to our evaluation waitlist. Appropriate evaluation referrals are for individuals ages 2 and older that are suspected of having a developmental disorder and/or related learning or emotional problems. Concerns that may require referral to an affiliate or outside agency include: psychotic symptoms, suicidal ideation, and/or bipolar disorder. **Please note that individuals may be placed on our waitlist for several months before an appointment is scheduled.** Thank you the referral and please attach any notes that may assist in the evaluation of this child. Please call 315-797-6241 extension 284 with any questions regarding the referral process.

Physician Name: _____

Child's Name: _____ DOB: _____

Parent's Name: _____ Phone: _____

Medicaid #: _____

Address: _____

Presenting Problem/concerns: _____

Diagnoses under consideration: _____

Has this referral been discussed with parent? Yes: _____ No: _____

Additional Comments: _____

Name of person completing this form: _____ Date: _____

Please fax to the Kelberman Center (315) 749-7054 so we may add this child to our evaluation waitlist.