D10185

Children's of Alabama

Office Use Only:
MR identification label

Intensive Feeding Program

Physician, Psychologist, Clinical Nutritionist, Occupational Therapist, Speech-Language Pathologist, and Social Work

Referral for Intensive Feeding Evaluation
For Questions Call (205) 638- 7590

Physician Office Instructions: ***This form must be faxed to the Scheduling Office at (205)638-7995 prior to the scheduling an appointment.***

Patient Name: _____ **Birthdate:** _____

Parent(s): _____ **Phone(s):** _____

Patient Address: _____

Referring Physician: (please print) _____

Referring Physician Address: _____ **Office Phone:** _____

_____ **FAX:** _____

☐ **Interpreter Needed (Please note type** _____**)**

Patient referred for feeding difficulty (ICD-10 R63.3):

☐ **Evaluate and Treat** ☐ **Second Opinion/Recommendation** ☐ **Other** _____

***Has your patient had any of the following? (*Please attach notes)**

☐ **Modified Barium Swallow**
☐ **Ph Impedance**
☐ **Chest X-rays**
☐ **Endoscopy/ EGD**
☐ **Blood Work**
☐ **UGI**
☐ **Gastric Emptying Scan**
☐ **Feeding Evaluations/ Therapy**
☐ **MRI/ CT Scans**
☐ **Other:** _____

Additional Diagnosis: _____

Allergies: _____

In order for the new appointment request process to be completed timely, the following information must be received prior to scheduling (attach sheets as necessary):

☐ **Growth charts** ☐ **Clinic Notes** ☐ **EPSDT referral required for Medicaid**

Current Medications: _____

_____

Type of Insurance: _____ **Insurance Number:** _____

Physician signature: _____ **Date:** _____ **Time:** _____

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