APPOINTMENT REQUEST FORM - *Child or Adolescent*

Please complete this form and submit so we can verify our clinic is appropriate for your needs.
Once we have reviewed it, we will instruct you to complete the rest of the new patient paperwork.

NAME OF PATIENT: First _____ Middle _____ Last _____

Nickname *(if applicable)* "_____" Date of Birth ___ / ___ / _____ Gender: __ Male __Female

What is the reason for the appointment request? _____

Is this a referral from another physician? **Yes** **No** If so what is the referring physician's name and address?

_____ Phone # (___) ___- _____

Does patient have a previous ADHD diagnosis? **Yes** **No** If "Yes" which professional made the diagnosis?
□ Psychologist □ Pediatrician □Family MD □Psychiatrist □Other _____

At the time of this diagnosis how old was the patient? _____ *yrs. old* What grade was patient in? _____

How was the diagnosis made? (check all that apply) □ Referral to psychologist
□ Interview by physician without testing □ Testing with Computer □ Checklists completed by parents
□ Full psychological and educational testing □ Checklists completed by teachers □ Other _____

Is patient currently under a physician's care for treatment of ADHD? **Yes** **No**
If "Yes," what is the reason for wishing to change from this physician or clinic? _____

What medications does patient currently take for ADHD? _____

What medications has patient taken in the past for ADHD? _____

OTHER CONDITIONS: For which other emotional / behavior health conditions has patient been treated or diagnosed?
□ Depression □ Generalized anxiety disorder □ Social anxiety disorder □ Obsessive compulsive disorder
□ Bipolar disorder □ Autism spectrum disorder (including "Asperger's") □ Disorder of sleep / Insomnia
Other _____

What medications does patient currently take emotional or behavioral health conditions? _____

_____

What medications has patient taken in the past for other emotional or behavioral health conditions? _____

_____

What other long-term medical problems does the patient have? _____

What other medications does patient take? _____

Name of Guarantor _____ Cell Phone # (__) ___- ____ Home Phone # (__) ___- ____

Mailing Address _____

City _____ State _____ Zip _____

Insurance Carrier _____Contract # _____ Group #_____

Phone # for Provider Benefits/Eligibility (____) ____- _____ *(refer to the back of your insurance card)*

options for returning the completed form

► **FAX:** 877-794-2293 *(secure)*
► **E**-MAIL: Tuscaloosa.appointments@focus-MD.com *(non-secure)*

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