siskin children's institute
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center for DEVELOPMENTAL PEDIATRICS
An academic pediatric practice affiliated with the University of Tennessee College of Medicine Chattanooga

Social Skills Physician Referral
All patients need a physician referral

Please complete this entire form and FAX to (423) 490-7750

Date of Request:
___/___/___

Patient Name _____
Last First Middle

Patient Date of Birth:		Age:	Sex:
Patient Street Address:			
Patient City:	State:	Zip Code:	County:
Parents or Legal Guardian of Patient:			
Custody (please attach documentation if not in parental custody):			
Home Telephone (Include Area Code):	Cell phone:		
Work Telephone:	E-mail:		
Primary Care Provider:			
PCP Telephone:	PCP Fax:		
Referring Provider (if different from PCP):			
Referring Provider Telephone:	Referring Provider Fax:		

PRIMARY INSURANCE:	***SECONDARY INSURANCE:***
Policy Holder and Date of Birth:	Policy Holder and Date of Birth:
Policy/Group #:	Policy/Group #:
ID #:	ID #:
Insurance Co. Phone #:	**Insurance Co. Phone #:**
Employer:	Employer:

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Social Skills Group Referral Form

Referrals for Ages (6 to 12 years)

Please choose one:

☐ **Referral for Social Skills Group (to include individual Speech Therapy)**

☐ **Referral for Social Skill Group Only**

Is child currently receiving speech therapy ☐ **Yes** ☐ **No**
(if child is currently in therapy please attach recent evaluation)

Medical diagnoses: _____

Medications: _____

Some of the Social Skills Group Topics-
- social perspective taking/thinking about others
- using flexible thinking
- determining expected and unexpected social behaviors in various social situations
- identifying and responding appropriately to social problems
- emotional coping strategies

Appropriate referrals-
- Children with social difficulties who:
  1. Demonstrate generally age-appropriate overall language skills
  2. Are able to attend to small group activities without 1:1 adult assistance

Referring Provider Signature: _____ **Office Phone**: _____
Print name: _____ **Office Fax**: _____
Name of Person Completing this form if other than Provider: _____