EAST TENNESSEE Children's Hospital

South Tower
2018 Clinch Avenue
Knoxville, TN 37916

Patient Label

Grow With Me Clinic Referral Request

Has the patient been seen by the University of Tennessee Medical Center Developmental clinic? ☐ Yes ☐ No

Please send the following information along with the referral form:

☐ Completed Referral form ☐ Demographics
☐ Physicians last office visit ☐ Guardianship papers

Child's name: _____ DOB: _____ Gender: _____
Child's social security number: _____
Parent guardian: _____ Phone: (____) _____
DCS caseworker: _____ Phone: (____) _____
Street address: _____
City: _____ State: _____ ZIP: _____

Medically Related Diagnosis

List: _____
_____

Patient History

Gestational age at birth: _____ Treated for NAS: ☐ Yes ☐ No
Treatment Hospital: _____ Date of discharge from birth hospital: _____
Maternal Substance Exposure/Use:
☐ Prescription (list) _____
_____
☐ Non-prescription (list) _____
_____
☐ Tobacco (#/day) _____ ☐ Alcohol (frequency) _____

Social History

Describe: _____
_____

Physician signature: _____ Date: _____ Time: _____
Physician name (*print*): _____ Date: _____ Time: _____
Phone: (_____) _____-_____

CLINIC REFERRAL

Return by fax to: (865) 541-8405