



Duke Children's HOSPITAL & HEALTH CENTER
Comprehensive Down Syndrome Clinic

Adult Referral Form

Today's Date: _____
M / D / Y

Patient's Name: _____
Last First Middle

Date of Birth: _____ **Current Age:** _____
Month / Day / Year

Address: _____
Street City State Zip Code

CONTACT INFORMATION:

Guardian 1: _____
Name Home Phone Work Phone Cell Phone

Guardian 2: _____
Name Home Phone Work Phone Cell Phone

Guardian's Address (If different from above):

Name Street City State Zip Code

MEDICAL INFORMATION:

Local Physician: _____ **Phone:** _____

Address: _____
Street City State Zip Code

Referring Physician: _____ **Phone:** _____

Address: _____
Street City State Zip Code

**Is the patient seen by someone from your local health department? (Caseworker/
Nurse) Name:** _____ **Phone:** _____

Is the patient involved in a school?

Circle: Y / N Name: _____

Address: _____
Street City State Zip Code



Which services are currently being received? (OT, PT, Speech, etc.)

Service	Name of Provider	Location

Service	Name of Provider	Location

Service	Name of Provider	Location

Has the patient been seen by an ophthalmologist?

Circle: Y / N Name: _____ Date of Last Visit: _____
Month / Year

Has the patient had an audiology exam?

Circle: Y / N Location: _____ Date of Last Visit: _____
Month / Year

Has the patient seen an ENT specialist?

Circle: Y / N Name: _____ Date of Last Visit: _____
Month / Year

Has the patient had an echocardiogram?

Circle: Y / N Location: _____ Date of Last Visit: _____
Month / Year

Was the patient diagnosed with Down syndrome prenatally or postnatally?

Circle: Prenatally / Postnatally Karyotype Result: _____

Has the patient had a neck X-Ray?

Circle: Y / N Date of Last X-Ray: _____
Month / Year

Has the patient had a thyroid test?

Circle: Y / N Date of Last Test: _____
Month / Year

Has the patient been seen at Duke before?

Circle: Y / N Name(s) of Physician(s): _____



Physician specialists you wish to continue following the patient (including Duke specialists):

Name	Location	Specialty
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Name	Location	Specialty
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Name	Location	Specialty
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During your visit:

Would you like to see a **genetic counselor** to discuss genetic and family support concerns regarding Down syndrome? Circle: Y / N

Would you like to see a **nutritionist** to discuss feeding or diet concerns? Circle: Y / N

Please list any concerns: _____

Please fax this completed form to the attention of **Blythe Crissman, MS, CGC** at **(919) 668-0414**. We will call within two business days with appointment date and time. You will also receive a packet in the mail with information about your clinic visit.

 For Office Use Only:

Scheduled Visit			
Date of Appt		Time of Appt	
Physician		Bloodwork	
Genetic Counselor		Nutritionist	
Hearing		Vision	
OT		PT	
Speech		Other	