YOUNG ADULT MEDICINE

EMAIL or FAX COMPLETED FORM

PATIENT INFORMATION

Patient Name _____

Date of birth _____ Phone _____

Parent/Guardian _____

REASON FOR REFERRAL

- ☐ Fevers, allergies, sore throat, and pink eve
- ☐ Skin rashes, dry skin, itching, eczema and acne
- ☐ Well Child Checks age 5+ Vaccines available via mbile-service
- ☐ Vomiting, Diarrhea, Constipation
- ☐ Camp and Sports Physicals when telehehalth appropriate
- ☐ Reproductive Health counseling including Medication
- ☐ Growth and Weight Optimization including medication
- ☐ ADHD evaluation and Medication management
- ☐ In-depth Mental Health Services 12yr and older
- ☐ School Stress and Peer challenges
- ☐ Nutrition and Sleep Support
- ☐ Transition from Middle-School-High-School and High School-College
- ☐ Follow up after Emergency Department visit
- ☐ Referral to Specialists when appropriate

Other: _____

REFERRING PROVIDER

Referring Provider _____ Email _____

Phone _____ Fax _____

Phone: 702–259–1228 Fax: 775-490-0161 Email: hello@youngadultmedicine.com