YOUNG ADULT MEDICINE

EMAIL or FAX COMPLETED FORM

PATIENT INFORMATION

Patient Name		Date of Birth	
Parent/Guardian		Phone	

REASON FOR REFERRAL

- ☐ Fevers, allergies, sore throat, and pink eye
- ☐ Skin rashes, dry skin, itching, eczema and acne
- ☐ Well Child Checks age 5+
- ☐ Vaccines available via mobile service
- ☐ Vomiting, Diarrhea, Constipation
- ☐ Camp and Sports Physicals when telehealth 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:

REFERRER INFORMATION

Referrer		Phone	
FAX		Practice	

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