Center for Advancement of Youth (CAY)/ Child Development Center (CDC)
at University of Mississippi Medical Center
(**CAY**)Telephone # (601) 984-4465 (**CAY**) Fax # (601) 815-8209
(CDC) 601-984-5236 (**CDC**) Fax # (601-984-2975)

NEW PATIENT REFERRAL REQUEST FORM

We do not accept referrals for custody evaluations, forensic evaluations, divorce counseling, active suicidal ideations, or inpatient hospitalization. If you have questions pertaining to the referral process, please call (601) 984-4465 or (601)984-5236. IMPORTANT: Incomplete referrals will NOT be processed and WILL be returned to the referring provider.

Today's Date:_____

PATIENT INFORMATION

Patient's Legal Name: _____ Patient's Preferred Name:_____
Patient's DOB: _____ Patient's SSN: _____ Sex: □ Male □ Female
Parent/Guarantor: _____ E-mail:_____
Mailing Address:_____
City, State, Zip Code: _____
Home Phone:_____ Other Phone: _____
Preferred Methods of Contact: □ Telephone □ E-mail □ Mail □ Text □ Other:_____

PAY SOURCE

□ Medicaid #: _____ □ CHIP #: _____
□ MS CAN Magnolia #: _____ □ MS CAN United Healthcare #: _____
□ Cash/Self-Pay □ Other Insurance Co. Name & Policy #: _____
We are providers for BCBS, CHIP, MS Physician Care NETWORK, MS Medicaid (regular, MS CAN, Magnolia/United Healthcare), Aetna, and PPO Plus. If you do not see your carrier on this list, please call our office at (601) 984-4465 to inquire.

REASON FOR REFERRAL *(Completed by Physician/Nurse Practitioner) Please* ***PRINT*** *legibly and be* ***SPECIFIC****.*

What is the primary complaint? _____

How can we help you with this patient? What services are you requesting?_____

Other concerns:_____

In the event that, following our evaluation, medication management and follow-up is felt to be indicated for this patient, would you prefer that this be conducted by (CIRCLE ONE OPTION):

(CAY / CDC Personnel) OR (YOURSELF, with recommendations by CAY/CDC Personnel)

Comments:_____
Referring Provider: _____ **Referring Clinic:** _____
Address: _____
City, State, Zip Code: _____
Phone #: _____ **Fax #:**_____
Are you the Primary Care Physician? □ Yes □ No If no, please list the patient's primary care physician: _____

Signature of referring provider/contact person: _____