Achieve Center
520 N 28th Ave
Wausau, WI
Phone: 715-845-4900
Fax: 715-254-9453

ACHIEVE CENTER
PATIENT CONSULTATION REQUEST

Patient Name_____ **DOB:**_____

Patient Phone Number:_____

Parent Name:_____

Address:_____

_____

Please include with this consultation request as available:

_____ Copy of newborn records and newborn screening results
_____ Copy of growth chart.
_____ Copy of recent well child check up- please have current (within one year).
_____ Copy of developmental or behavioral screening tools and results
_____ Copies of subspecialty evaluations
_____ Copy of signed Release of Information Form for entire medical record
_____ Copy of Client Demographic Information sheet

Please State:

1. The main reason I am seeking consultation for this patient is:

2. The secondary issues are:

3. Family dynamics to be aware of are:

4. I am specifically seeking:

_____ Patient's specific needs to be determined by Achieve Team
_____ Neuropsychological Developmental Behavioral Assessment
_____ Psychological Assessment (mood and behavior evaluation)
_____ Behavioral/cognitive treatment, parent training and counseling services for patient and Family
_____ Speech and Language Assessment and Treatment (**A script which states this will be needed as well**)

I prefer to receive feedback:

_____ By receiving a full report from the Achieve Team
_____ Summary of findings and recommendations (this would get to you quicker)

Signature of Physician: _____ **Date:** _____

Print Physician's Signature: _____

Clinic Name:_____ **Phone #:**_____

Rev. 2/14

Fax #:_____