YOUNG ADULT MEDICINE

EMAIL or FAX COMPLETED FORM

PATIENT INFORMATION

Patient Name		Date of Birth	
Parent/Guardian		Phone	

REASON FOR REFERRAL **(please mark all that apply)**

- ☐ 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 to High School OR High School to College
- ☐ Follow up after Emergency Department visit
- ☐ Referral to Specialists when appropriate

☐ Other:

REFERRING PROVIDER INFORMATION

Name		Phone	
Fax		Practice	