

Center for Children with Special Needs
 Floating Hospital for Children
 Mailing address: New England Medical Center #334
 750 Washington Street
 Boston, MA 02111
 Telephone: (617) 636-7242
 Fax: (617) 636-5621



Child's Name: _____ DOB: _____

Physician Report

Your patient's parent has requested an evaluation at the CCSN. We would appreciate the following information to help us with the assessment process. Thank you.

Date: _____ Physician Name: _____

Person completing form: _____

Office Address: _____
Street address City State Zip Code

Phone #: _____ Fax #: _____ Email: _____

◆ How long have you been the child's primary care provider? _____

◆ Did you refer this patient for evaluation at the CCSN? **No Yes**

Please specify your questions and/or the type of evaluation(s) you would like for this child:

◆ What are your concerns about this child's development, behavior or emotional state?

◆ What aspects of social or family history should we know?

◆ What aspects of medical history should we know?

◆ Is the child currently on any regular medications? **No Yes**

If **Yes**, please specify:

Sensory Testing	Date	Results
Vision Testing		
Hearing Testing		

You will receive a report after the evaluation is completed. Please contact us if you have any questions or further comments or would like to discuss this patient before the evaluation.

Thank you,
 - The Staff of the Center for Children with Special Needs