



Developmental Pediatrics and Genetics
DOWN SYNDROME CENTER
135 Rutledge Avenue
PO Box 250567
Charleston, SC 29425
(843) 876-1511
(843) 876-1518 (fax)

Dear Provider,

Thank you for your referral to the Medical University of South Carolina's Down Syndrome Center. We will need the following information before the patient can be scheduled. Please include any material that may be relevant to this evaluation. This may include lab work, radiology reports, therapy evaluations, school evaluations, psychology evaluations and an Individual Education Plan.

The patient will be scheduled for the next available appointment. Our clinic is the second Thursday of every month.

If you have any questions, please contact Karen van Bakergem at 876-1524. For long distance, please dial (800) 424-MUSC ext. 6-1524. The fax number is (843) 876-1518. Thank you.

Angela LaRosa, MD
Medical Director
MUSC Down Syndrome Center

Karen van Bakergem, LMSW
Clinic Coordinator
MUSC Down Syndrome Center

**REFERRAL TO MUSC DOWN SYNDROME CENTER
FAX TO (843) 876-1518**

Date of referral: _____

DEMOGRAPHICS:

Child's Name:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Age:
Date of Birth:	SS#:	
Parent or Guardian:		
Address:		
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION:

Primary Insurance:		
Company Name:	Policy Number:	Phone #
Secondary Insurance:		
Company Name:	Policy Number:	Phone #
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid ID #:	
Type of Medicaid (check one):		
<input type="checkbox"/> Regular	<input type="checkbox"/> First Choice	<input type="checkbox"/> PEP <input type="checkbox"/> MCCM <input type="checkbox"/> Other:

PATIENT MEDICAL INFORMATION: (perinatal, past medical and surgical history)

CONCERNS:

PRIMARY CARE PROVIDER:

REFERRING PROVIDER:

Name:	Name:
Practice:	Practice:
Address:	Address:
Phone:	Phone:
Fax:	Fax: