



South Tower
2018 Clinch Avenue
Knoxville, TN 37916

Patient Label

Grow With Me Clinic Referral Request

Has the patient been seen by the University of Tennessee Medical Center Developmental clinic? [] Yes [] No

Please send the following information along with the referral form:

- [] Completed Referral form [] Demographics
[] Physicians last office visit [] Guardianship papers

Child's name: _____ DOB: _____ Gender: _____
Child's social security number: _____
Parent guardian: _____ Phone: (____) _____
DCS caseworker: _____ Phone: (____) _____
Street address: _____
City: _____ State: _____ ZIP: _____

Medically Related Diagnosis

List: _____

Patient History

Gestational age at birth: _____ Treated for NAS: [] Yes [] No
Treatment Hospital: _____ Date of discharge from birth hospital: _____
Maternal Substance [] Prescription (list) _____
Exposure/Use: _____
[] Non-prescription (list) _____
[] Tobacco (#/day) _____ [] Alcohol (frequency) _____

Social History

Describe: _____

Physician signature: _____ Date: _____ Time: _____
Physician name (print): _____ Date: _____ Time: _____
Phone: (____) _____ - _____



Return by fax to: (865) 246-7568