____ _______________________

Patient Name Date of Birth

Integrative Developmental and Behavioral Pediatrics, LLC

Medical and Behavioral Care Provider Communication List

Communication between providers is essential to optimize care. Please provide contact information below about your child's care team to that we can communicate with them as needed. (Example: Naturopath, Acupuncturist, OT, SLP, PT, psychologist or other mental or behavioral health therapist**). <u>In addition to the information below, we will need a signed "Release of Information" form to communicate with each provider.</u>**

Primary Care Physician____Phone No.______________________

Address____Fax #_________________________

City/State/Zip_______________________________________Email____

Name____Phone No.__________________________

Address____Fax #_________________________

City/State/Zip_______________________________________Email____

Name____Phone No.__________________________

Address____Fax _________________________

City/State/Zip_______________________________________Email____

Name____Phone No.__________________________

Address____Fax _________________________

City/State/Zip_______________________________________Email____

Name____Phone No.__________________________

Address____Fax _________________________

City/State/Zip_______________________________________Email____