

# Specialty Referral Form

- Adolescent Med
- Allergy/Immunology
- Allergy/Pulmonology
- Audiology
- Cardiology
- Chairman's Clinic (undetermined or multiple diagnostic referral)
- C.H.O.I.C.E.S. (medical home)
- Comprehensive Bleeding Disorders
- Congenital Diaphragmatic Hernia
- CV Surgery
- Cystic Fibrosis
- Developmental Peds
- Diabetes
- Endocrine
- ENT
- Gastro
- General/Thoracic Surgery
- Genetics
- Home Vent
- Infectious Disease
- Nephrology
- Neurology
- Neuropsychology
- Neurosurgery
- Ophthalmology
- Orthopaedic
- Plastic Surgery
- Primary Peds (University)
- Psychiatry
- Psychology
- Resource Link
- Spina Bifida
- St. Jude Clinic (Hem/onc/sickle cell)
- Urology

Today's Date: \_\_\_\_\_ Interpreter Needed  Yes  No What Type? \_\_\_\_\_  
 Specialist Preferred/Requested: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ Test Ordered: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_  
First, Middle, Last  
 DOB: \_\_\_\_\_ Sex:  M  F SS# \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Parent/Legal Guardian Information**

Mother's Name: \_\_\_\_\_  
First, Last  
 Father's Name: \_\_\_\_\_  
First, Last  
 Other Relationship: \_\_\_\_\_ Name: \_\_\_\_\_  
First, Last  
 Address (if different): \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_\_ Pager Phone: (\_\_\_\_) \_\_\_\_\_

**Primary Insurance Company**

Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_  
 Policy#/Certificate#/Acct#: \_\_\_\_\_  
 HMO/PPO: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Relation to Patient: \_\_\_\_\_  
 Prior Approval Needed:  Yes  No  
 Prior Approval # \_\_\_\_\_ # of Visits \_\_\_\_\_

**Secondary Insurance Company**

Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_\_  
 Policy#/Certificate#/Acct#: \_\_\_\_\_  
 HMO/PPO: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Relation to Patient: \_\_\_\_\_  
 Prior Approval Needed:  Yes  No  
 Prior Approval # \_\_\_\_\_ # of Visits \_\_\_\_\_

**Primary Care Physician (PCP)**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Access Phone: \_\_\_\_\_  
 Office Phone: (\_\_\_\_) \_\_\_\_\_  
 Fax: (\_\_\_\_) \_\_\_\_\_  
 NPI#/UPIN: \_\_\_\_\_  
 Referral Contact Name/Number: \_\_\_\_\_

**Referring Physician (RP) (if different than PCP fill in below)**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Access Phone: \_\_\_\_\_  
 Office Phone: (\_\_\_\_) \_\_\_\_\_  
 Fax: (\_\_\_\_) \_\_\_\_\_  
 NPI#/UPIN: \_\_\_\_\_  
 Referral Contact Name/Number: \_\_\_\_\_

**PCP Signature:** \_\_\_\_\_

**RP Signature:** \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Today's Date \_\_\_\_\_  
First, Middle, Last

**Additional Patient Information**

Diagnosis/Reason for Referral: \_\_\_\_\_

Current Meds: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Diagnostic Tests/Lab Work Completed: *(please list all with date and test location noted and fax over copies)*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Reason for appointment shared with family: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Seen by other specialist:  Yes  No If yes, who? *(please list all)* \_\_\_\_\_

**SPECIALIST OFFICE USE ONLY**

**Appointment Information**

Appointment scheduled:  Yes  No Information sent to family:  Yes  No

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_

Appointment with Dr. \_\_\_\_\_

Form Completed by / Date: \_\_\_\_\_ Form Confirmed by / Date: \_\_\_\_\_

Received by / Date: \_\_\_\_\_ Appointment Scheduled: \_\_\_\_\_  
 \_\_\_\_\_ Dr. Notes for Specialty: \_\_\_\_\_

Info/Labs Received from RP: \_\_\_\_\_

Directions Mailed to Patient: \_\_\_\_\_

New Patient Info Sent: \_\_\_\_\_

Info in Computer: \_\_\_\_\_

Type of Chart: \_\_\_\_\_

Chart Ready: \_\_\_\_\_

**Appointment Information faxed to Referring Physician office by:** \_\_\_\_\_ **Date:** \_\_\_\_\_