

Request for Referral of Pediatric Specialty Groups

PATIENT INFORMATION

DATE OF REFERRAL:		REFERRING OFFICE CONTACT NAME AND NUMBER:				
PATIENT'S LAST NAME:		FIRST:		MIDDLE:		
BIRTHDATE:			M <input type="checkbox"/> F <input type="checkbox"/>			
INSURANCE NAME:			ID #:			
STREET ADDRESS:			CITY:	STATE:	ZIP CODE:	
HOME PHONE: ()		CELL PHONE: ()		WORK PHONE: ()		
WILL FAMILY NEED AN INTERPRETER? YES <input type="checkbox"/> NO <input type="checkbox"/>		PRIMARY LANGUAGE SPOKEN:				
IS THIS CHILD IN FOSTER CARE? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, complete Case Manager Info			CASE MANAGER (CM) NAME: (last, first)		Phone:	

PARENT/LEGAL GUARDIAN INFORMATION

MOTHER'S NAME: LAST		FIRST:		MI	
FATHER'S NAME: LAST		FIRST:		MI	
LEG. GUARDIAN'S NAME: LAST		FIRST:		RELATION TO CHILD:	
LEG. GUARDIAN'S ADDRESS IF DIFFERENT FROM CHILD'S: STREET ADDRESS					
CITY:	STATE:	ZIP CODE:	HOME PHONE: ()	CELL PHONE: ()	

SPECIALTY REQUESTED: (FAX NUMBERS LISTED BELOW)

<input type="checkbox"/> ACUPUNCTURE	502-588-2551	<input type="checkbox"/> NEPHROLOGY	502-588-7712
<input type="checkbox"/> ALLERGY	502-588-9535	<input type="checkbox"/> NEUROLOGY	502-588-7852
<input type="checkbox"/> CARDIOLOGY	502-589-1256	<input type="checkbox"/> PSYCHIATRY	502-588-0801
<input type="checkbox"/> ENDOCRINOLOGY	502-588-3401	<input type="checkbox"/> PULMONOLOGY	502-588-7712
<input type="checkbox"/> WENDY NOVAK DIABETES CTR.	502-588-3401	<input type="checkbox"/> RHEUMATOLOGY	502-588-9554
<input type="checkbox"/> GASTROENTEROLOGY	502-588-9513	<input type="checkbox"/> SLEEP	502-588-2221
<input type="checkbox"/> HEMATOLOGY/ONCOLOGY	502-588-9536	<input type="checkbox"/> UROLOGY	502-588-9537
<input type="checkbox"/> IMMUNODEFICIENCY CLINIC	502-588-2334	<input type="checkbox"/> WCEC DEVEL./GENETICS	502-588-9534
<input type="checkbox"/> INFECTIOUS DISEASE	502-588-2334	<input type="checkbox"/> UofL AUTISM CENTER	502-588-0721
<input type="checkbox"/> NEONATAL FOLLOW UP	502-588-0984		

Does this patient need an urgent appointment? ___Yes ___No

Do you want this patient scheduled with a specific provider? ___Yes ___No If so, with whom? _____

(Note: Requesting a specific provider may cause delays in appointment scheduling.)
REASON FOR REFERRAL:

Presenting Concerns:	PLEASE ATTACH LAST H&P AND ANY TEST RESULTS
Current Diagnosis / Rule-Out Diagnosis: (if any)	PLEASE ATTACH COPY OF REFERRAL IF NEEDED

REFERRING PHYSICIAN INFORMATION:

Are you the Patient's Primary Care Physician? Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, list PCP Name and Phone Number Below.	
PCP Name:		PCP Phone Number:	Doctor's NPI #
Referring Physician's Name (Printed)		Address:	
City	State	Zip Code	County
Group Name			
Office Phone	Fax Number	Private Physician #:	Email Address:

OFFICE USE ONLY:

Date and Time of Appointment:	Provider:
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