

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:	
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:		MIDDLE:		
FATHER'S NAME: LAST		FIRST:		MIDDLE:		
LEG. GUARDIAN'S NAME: LAST:		FIRST:		RELATION TO CHILD:		
LEG. GUARDIAN'S ADDRESS (IF DIFFERENT FROM CHILD) STREET ADDRESS:						
CITY:	STATE:	ZIP:	HOME PHONE: ()	CELL PHONE: ()		
SPECIALTY REQUESTED: FAX NUMBERS LISTED BELOW						
<input type="checkbox"/> ACUPUNCTURE 502-588-2551		<input type="checkbox"/> NEPHROLOGY 502-588-7713		<input type="checkbox"/> NEUROLOGY 502-588-7852		
<input type="checkbox"/> ALLERGY 502-588-9535		<input type="checkbox"/> PSYCHIATRY (Bingham Clinic) 502-588-0801		<input type="checkbox"/> PULMONOLOGY 502-588-7712		
<input type="checkbox"/> CARDIOLOGY 502-588-7728		<input type="checkbox"/> RHEUMATOLOGY 502-588-9554		<input type="checkbox"/> SLEEP 502-588-2221		
<input type="checkbox"/> ENDOCRINOLOGY 502-588-3401		<input type="checkbox"/> UROLOGY 502-588-9537		<input type="checkbox"/> WEISSKOPF CENTER/GENETICS 502-588-9534		
<input type="checkbox"/> WENDY NOVAK DIABETES CTR. 502-588-3401		<input type="checkbox"/> UofL AUTISM CENTER 502-588-0721				
<input type="checkbox"/> GASTROENTEROLOGY 502-588-9513						
<input type="checkbox"/> HEMATOLOGY/ONCOLOGY 502-588-9536						
<input type="checkbox"/> IMMUNODEFICIENCY CLINIC 502-588-2334						
<input type="checkbox"/> INFECTIOUS DISEASE 502-588-2334						
<input type="checkbox"/> NEONATAL FOLLOW-UP 502-588-0987						
Does this patient need an urgent appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want this patient scheduled with a specific provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, whom? _____ <i>(Note: Requesting a specific provider may cause delays in appointment scheduling.)</i>						
REASON FOR REFERRAL:						
Presenting Concerns:			<u>PLEASE ATTACH LAST H&P AND ANY TEST RESULTS</u>			
CURRENT DIAGNOSIS/RULE-OUT DIAGNOSIS (if any):			<u>PLEASE ATTACH COPY OF REFERRAL IF NEEDED</u>			
REFERRING PHYSICIAN INFORMATION:						
Are you the Patient's Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No 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:	Private Physician #		Email Address:	