PEDIATRIC _____ (FILL IN SPECIALTY) CONSULTATION FORM

DATE OF APPOINTMENT:	HISTORY#:
REASON FOR REFERRAL:	

PATIENT INFORMATION

PATIENT:		
SOCIAL SECURITY NUMBER:	DOB:	SEX:
ADDRESS:		
HOME PHONE:	ALTERNATE PHONE:	
INTERPRETER REQUIRED?	LANGUAGE:	

RESPONSIBLE PARTY

PARENT/GUARDIAN:	
PARENT SOCIAL SECURITY:	DOB:
ADDRESS:	
HOME PHONE:	ALTERNATE PHONE:

INSURANCE INFORMATION

INSURANCE COMPANY:	
AUTHORIZATION REQUIRED?	AUTHORIZATION NUMBER:

PHYSICIAN INFORMATION

PHYSICIAN REQUESTING CONSULTATION:	
ADDRESS:	
PHONE NUMBER:	FAX NUMBER:
NPI NUMBER:	
SECOND OPINION?	IF YES, PHYSICIAN NAME/NUMBER
PCP?	IF NOT, PCP NAME:
ADDRESS:	
PHONE NUMBER:	FAX NUMBER:

URGENCY OF APPOINTMENT: (CHECK ONE)

- ☐ EMERGENCY (WITHIN 24 HOURS). Referring physician should speak with specialist and all relevant information should be faxed to the specialist's office immediately.
- ☐ SOON (1-2 WEEKS)
- ☐ ROUTINE (4-8 WEEKS)

THE FOLLOWING REPORTS ARE ATTACHED: (Please select one or more of the following)

- ☐ BRIEF NOTE FROM PROVIDER REGARDING NATURE OF CONSULT
- ☐ LAB RESULTS
- ☐ RADIOLOGY RESULTS
- ☐ OTHER _____

REFERRAL MADE BY: _____ CONTACT #: _____

Levine Children's Hospital | Specialty Center

FAX to 704-381-8836