Carolinas HealthCare System
Levine Children's Hospital

Pediatric Hematology and Oncology
Blood and Marrow Transplant Program

NEW PATIENT REFERRAL FORM
Phone: (704) 381-9900
Fax: (704) 381-9901

DATE REQUESTED: _____ REASON FOR REFERRAL: _____

PATIENT INFORMATION

Patient's Legal Name:	Date of Birth:	Gender: ☐ M ☐ F	
Patient's Social Security Number:	Street Address:		
Interpreter Required? ☐ Yes ☐ No If Yes, Language/Dialect: _____	City:	State:	Zip Code:

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:	Date of Birth:	Parent's Social Security Number:	
Primary/Alternate Phone Number:	Street Address (*if different from above*):		
E-mail Address:	City:	State:	Zip Code:

INSURANCE/AUTHORIZATION INFORMATION ****Copy of Insurance Card Required to Process Referral***

Subscriber Name/Relationship to Patient:	Subscriber Date of Birth:
Subscriber Social Security #:	Subscriber/Insurance ID #:
Insurance Carrier: ***Cannot Accept SC Blue Choice or BC/BS BLUE VALUE Plans***	Group ID #:
Authorization Number: ***Prior Authorization Required for NC Medicaid***	Authorization Valid From: _____ to _____ Number of Visits Authorized: _____

REFERRING PROVIDER INFORMATION *** Is this the patient's PCP? ☐ Yes ☐ No-PCP Name: _____***

Practice Name:	Practice Address:
Referring Provider Name:	Phone Number:
Referring Provider NPI#:	Fax Number:
Referring Provider E-mail:	Practice Contact Name/Phone Number:

REFERRAL APPOINTMENT INFORMATION

Please Indicate Urgency of Referral Request:
☐ SOON (1-2 Weeks)
☐ ROUTINE (2-6 Weeks)
☐ EMERGENCY (Within 24 Hours)
Note: *For Emergency Needs, Referring Physician should speak with Specialist and all relevant information should be faxed to the Specialist's office immediately.*

Please Indicate Office Preference:
☐ Medical Center Plaza (Next to Levine Children's Hospital)
1001 Blythe Blvd Suite 601 Charlotte, NC 28203

☐ Outpatient Pavilion (Next to Jeff Gordon's Hospital)
100 Medical Park Drive NE Suite 310 Concord, NC 28025
Concord Appointments on Monday Afternoons Only

Rev 1-2016

REQUIRED* - *Fax Patient Records With Referral Form:
- Copy of Patient Insurance Card
- Copy of Demographic Sheet
- Copy of Relevant Lab Results or ☐ IN CANOPY
- Copy of Relevant Scans/Reports or ☐ IN CANOPY
- Copy of Last 2-3 Provider Notes or ☐ IN CANOPY

We will be unable to process your referral without records.

Office Use: Referring Provider to Confirm with Patient.

Provider Scheduled: _____

Appointment Date: _____ Appointment Time: _____

Appointment Arrival Time: _____Initials: _____

Patients not Present at Arrival Time will be Rescheduled.