Physicians
Pediatrics

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 ☐ F ☐	
INSURANCE NAME:		ID#:	
STREET ADDRESS:		CITY:	STATE: ZIP:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )	
WILL FAMILY NEED AN INTERPRETER? YES ☐ NO ☐		PRIMARY LANGUAGE SPOKEN:	
IS THIS CHILD IN FOSTER CARE? YES ☐ NO ☐ 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

☐ ACUPUNCTURE	502-588-2551	☐ NEPHROLOGY	502-588-7713
☐ ALLERGY	502-588-9535	☐ NEUROLOGY	502-588-7852
☐ CARDIOLOGY	502-588-7728	☐ PSYCHIATRY (Bingham Clinic)	502-588-0801
☐ ENDOCRINOLOGY	502-588-3401	☐ PULMONOLOGY	502-588-7712
☐ WENDY NOVAK DIABETES CTR.	502-588-3401	☐ RHEUMATOLOGY	502-588-9554
☐ GASTROENTEROLOGY	502-588-9513	☐ SLEEP	502-588-2221
☐ HEMATOLOGY/ONCOLOGY	502-588-9536	☐ UROLOGY	502-588-9537
☐ IMMUNODEFICIENCY CLINIC	502-588-2334	☐ WEISSKOPF CENTER/GENETICS	502-588-9534
☐ INFECTIOUS DISEASE	502-588-2334	☐ UofL AUTISM CENTER	502-588-0721
☐ NEONATAL FOLLOW-UP	502-588-0987		

Does this patient need an urgent appointment? ☐ Yes ☐ No

Do you want this patient scheduled with a specific provider? ☐ Yes ☐ No If so, 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 ☐ 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:

Date Revised: 7/17/18