

Norton Children's Medical Group, affiliated with UofL School of Medicine

PATIENT INFORMATION

Date of referral:		Referring office contact name and number:	
Patient's name: (Last)	First:	Middle:	
Birthdate:		<input type="checkbox"/> M <input type="checkbox"/> F	
Insurance name:		ID#:	
Street address:		City:	State: ZIP:
Home phone: ()	Cellphone: ()	Work phone: ()	
Will family need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary language spoken:	
Is this child in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete case manager info ▶		Case manager name: (Last, First)	Phone: ()

PARENT/LEGAL GUARDIAN INFORMATION

Parent 1 name: (Last)	First:	Middle:	
Parent 2 name: (Last)	First:	Middle:	
Guardian's name: (Last)	First:	Relation to child:	
Guardian's street address (if different from child's):			
City:	State:	ZIP:	Home phone: () Cellphone: ()

PEDIATRIC SPECIALTY REQUESTED (WITH FAX NUMBERS LISTED)

<input type="checkbox"/> Acupuncture	(502) 588-2551	<input type="checkbox"/> Neonatal (follow-up)	(502) 588-0987
<input type="checkbox"/> Allergy	(502) 588-9535	<input type="checkbox"/> Nephrology	(502) 588-7713
<input type="checkbox"/> Autism Center	(502) 588-0721	<input type="checkbox"/> Neurology	(502) 588-7852
<input type="checkbox"/> Behavioral & Mental Health	(502) 588-0801	<input type="checkbox"/> Neurosurgery	(502) 540-7270
<input type="checkbox"/> Cardiology	(502) 588-7728	<input type="checkbox"/> Orthopedics	(502) 394-5600
<input type="checkbox"/> Dermatology	(502) 266-2632	<input type="checkbox"/> Pediatric/Adolescent Gynecology	(502) 666-7707
<input type="checkbox"/> Development Center	(502) 588-9534	<input type="checkbox"/> Pediatric Surgery	(502) 588-0396
<input type="checkbox"/> Endocrinology	(502) 588-3401	<input type="checkbox"/> Physical Medicine and Rehabilitation	(502) 588-7776
<input type="checkbox"/> ENT & Audiology	(502) 588-9580	<input type="checkbox"/> Pulmonology	(502) 588-9553
<input type="checkbox"/> Eye Care	(502) 588-0554	<input type="checkbox"/> Radiology	(502) 629-5309
<input type="checkbox"/> Gastroenterology	(502) 588-9513	<input type="checkbox"/> Rheumatology	(502) 588-9554
<input type="checkbox"/> Genetics Center	(502) 588-0861	<input type="checkbox"/> Sleep Medicine	(502) 588-2221
<input type="checkbox"/> Hematology/Oncology	(502) 588-9536	<input type="checkbox"/> Urology	(502) 394-1999
<input type="checkbox"/> Infectious Diseases	(502) 588-2334	<input type="checkbox"/> Wendy Novak Diabetes Center	(502) 588-3401

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:	Attach last H&P and any test results
Current diagnosis/rule-out diagnosis (if any):	Attach copy of referral if needed

REFERRING PROVIDER INFORMATION

Are you the patient's primary care provider? Yes No If no, list PCP name and phone number below:

PCP name:	PCP phone: ()	Provider's NPI#
Referring provider's name:		Street address:
City:	State:	ZIP: County:
Group name:	Office phone: ()	Fax: ()
Direct phone: ()	Email address:	

