

**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				
PARENT 1 NAME: LAST		FIRST:		MIDDLE:
PARENT 2 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"/> ALLERGY                                502-588-9535		<input type="checkbox"/> NEUROLOGY                            502-588-7852		
<input type="checkbox"/> CARDIOLOGY                            502-588-7728		<input type="checkbox"/> PSYCHIATRY (Bingham Clinic)    502-588-0801		
<input type="checkbox"/> ENDOCRINOLOGY                    502-588-3401		<input type="checkbox"/> PULMONOLOGY                        502-588-7712		
<input type="checkbox"/> WENDY NOVAK DIABETES CTR.    502-588-3401		<input type="checkbox"/> RHEUMATOLOGY                       502-588-9554		
<input type="checkbox"/> GASTROENTEROLOGY                502-588-9513		<input type="checkbox"/> SLEEP                                    502-588-2221		
<input type="checkbox"/> HEMATOLOGY/ONCOLOGY            502-588-9536		<input type="checkbox"/> UROLOGY                                502-588-9537		
<input type="checkbox"/> IMMUNODEFICIENCY CLINIC       502-588-2334		<input type="checkbox"/> WEISSKOPF CENTER/GENETICS    502-588-9534		
<input type="checkbox"/> INFECTIOUS DISEASE                502-588-2334		<input type="checkbox"/> UofL AUTISM CENTER                502-588-0721		
<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? _____ (Note: Requesting a specific provider may cause delays in appointment scheduling.)				
REASON FOR REFERRAL:				
Presenting Concerns:			<u>PLEASE ATTACH LAST H&amp;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:	