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:		☐ M ☐ F	
Insurance name:		ID#:	
Street address:	City:	State:	ZIP:
Home phone: ( )	Cellphone: ( )	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 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)

☐ Acupuncture	(502) 588-2551	☐ Orthopedics	(502) 394-5600
☐ Allergy	(502) 588-9535	☐ Pediatric Surgery	(502) 588-0396
☐ Autism	(502) 588-0721	☐ Ped/Adolescent Gynecology	(502) 666-7707
☐ Cardiology	(502) 588-7728	☐ Physical Medicine and Rehabilitation	(502) 588-7776
☐ Endocrinology	(502) 588-3401	☐ Pulmonology	(502) 588-7712
☐ Gastroenterology	(502) 588-9513	☐ Radiology	(502) 629-5309
☐ Hematology/Oncology	(502) 588-9536	☐ Rheumatology	(502) 588-9554
☐ Infectious Diseases	(502) 588-2334	☐ Sleep Medicine	(502) 588-2221
☐ Mental and Behavioral Health	(502) 588-0801	☐ Urology	(502) 394-1999
☐ Neonatal (follow-up)	(502) 588-0987	☐ Weisskopf Center – Development	(502) 588-9534
☐ Nephrology	(502) 588-7713	☐ Weisskopf Center – Genetics	(502) 588-0861
☐ Neurology	(502) 588-7852	☐ Wendy Novak Diabetes Center	(502) 588-3401
☐ Neurosurgery	(502) 583-2120		

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:		

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