SPECTRUM HEALTH
Helen DeVos children's hospital

Referral
NEW APPOINTMENT - PEDIATRIC

REFERRAL TO

PEDIATRIC SPECIALTY OFFICES ***(Check appropriate box and fax to corresponding number listed on "Specialty Appointment Guidelines")***

- ☐ Adolescent Medicine
- ☐ Allergy and Immunology
- ☐ Behavioral (5 years and under)
- ☐ Bone Dysplasia
- ☐ Bone Marrow Transplant
- ☐ Cardiology
- ☐ Cardiovascular/Thoracic Surgery
- ☐ Center for Child Protection
- ☐ Children's Heart, Lansing
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ General Pediatrics
- ☐ Healthy Weight Center
- ☐ Hematology/Oncology
- ☐ Infectious Disease/HIV
- ☐ Intensive Feeding Program
- ☐ Nephrology
- ☐ Neurodevelopmental
- ☐ Neurofibromatosis
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Ophthalmology
- ☐ Oral Cleft
- ☐ Orthopaedics
- ☐ Plastic Surgery/Craniofacial
- ☐ Psychology
- ☐ Pulmonary/Sleep
- ☐ Rheumatology
- ☐ Other ______

Fax number ______

Date of request ______ Office staff contact ______ Direct phone ______ Extension ______

PATIENT INFORMATION (PRINT) ☐ Male ☐ Female Medical record number ______ (Internal only)

Last name ______ First name ______

Address ______ City ______ State ______ Zip ______

Date of birth ___/___/___ Interpreter needed? ☐ No ☐ Yes, language ______

Phone numbers: Home (____) ______ Cell (____) ______

Work (____) ______ Emergency (____) ______

Parents(s)/Guardian name ______ Guardian DOB ______

Type of Insurance: ☐ BCBS ☐ Medicaid ☐ Medicaid HMO ______ ☐ BCN ☐ Priority Health ☐ Other ______

Authorization number ______ Contract number ______ Subscriber name ______

REFERRING PHYSICIAN INFORMATION

Physician's name ______ National provider identification (NPI) number ______

Address ______ City ______ State ______ Zip ______

Office phone (____) ______ Office fax (____) ______

PRIMARY CARE PHYSICIAN (IF DIFFERENT FROM REFERRING)

Physician's name ______ National provider identification (NPI) number ______

Office phone (____) ______ Office fax (____) ______

REASON FOR REQUEST ***(CHECK ONE)***

New federal guidelines require your request to clearly indicate if this is a CONSULT versus a REFERRAL. Specify if your intent is for a ***CONSULT***: where we will evaluate and recommend treatment ***OR*** a ***REFERRAL***: where we will assume the care of the child for a specific condition.

☐ **I request a CONSULTATION** ***OR*** ☐ **I would like to REFER care**

For the following (Signs/Symptoms) ______

______

______

Appointment requested: ☐ Next available ☐ Within 2 weeks ☐ Emergent ☐ Second opinion ☐ Other ______

TIME ______ **DATE** ______ Referring Physician signature ______

In order for the new appointment request process to be completed in a timely manor, the following information must be received prior to scheduling:

(Refer to "Specialty Appointment Guidelines" for specific requirements)

- Growth charts
- Diagnostic reports
- Laboratory study results
- Prior authorization for appointment
- Clinic notes/Letter of request
- Copy of the insurance card/clinic registration face sheet.
- Radiology reports

TIME ______ **DATE** ______ of appointment given (Internal use only)

Physician name ______

CONFIDENTIAL NOTICE: The content of this fax is intended only for the named recipient(s) and may contain information that is protected under applicable law. If you are not the intended recipient(s) or if you receive this fax in error, please notify the sender at the address or telephone number above. Please also destroy any copies.

DO NOT MARK BELOW THIS LINE BARCODE ZONE DO NOT MARK BELOW THIS LINE

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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