Children's Physician Group

Provider referral form

Complete this form and fax it to 404-785-9111. Use one form for each patient.

If the patient needs to be seen within the next week, call 404-785-DOCS (3627) and do not fill out this form.

□ **Urgent** □ **Non-urgent**

_____
Today's date

Patient's name: _____

_____
Referral form completed by

Patient's date of birth: _____

Patient's gender: □ Male □ Female

_____
Direct contact phone number

Parent/guardian's name: _____

_____
Email

Cell phone: _____

Alternate phone: _____

Preferred method of communication for referring office (choose one):
□ Phone □ Email

Interpreter required: □ Yes □ No

If yes, provide the language: _____

Referring provider's name: _____

Office phone: _____

Office fax: _____

Referring provider's status with patient: □ PCP □ Not PCP

PCP name: _____

PCP phone: _____

Reason for referral: _____

_____

Specialty needed (choose one):

Allergy and immunology
- □ Allergy
- □ Immunology

□ **Apnea**

□ **Cardiology: pulmonary hypertension**

□ **Cardiothoracic surgery**

□ **Child advocacy**

□ **Craniofacial surgery**

□ **Cystic fibrosis**

□ **Dentistry and orthodontics**

□ **Diabetes**

Endocrinology
- □ Bone
- □ General endocrinology
- □ Lipid
- □ Transgender
- □ Turner syndrome

Gastroenterology
- □ Eosinophilic and allergic GI diseases
- □ Feeding (IEAT)
- □ General gastroenterology
- □ Growth problems
- □ Inflammatory bowel disease (Crohn's and ulcerative colitis)
- □ Intestinal rehabilitation

□ **General surgery**

□ **Gynecology**

□ **Hematology/oncology**

Hepatology
- □ General liver
- □ Liver transplant

□ **Infectious diseases**

Nephrology
- □ General nephrology
- □ Hypertension
- □ Kidney transplant

Neurology
- □ Developmental neurology
- □ General neurology
- □ Headache
- □ Neurocutaneous
- □ Neuromuscular
- □ New onset seizures

□ **Neuropsychology**

□ **Neurosurgery**

□ **Orthopaedics and sports medicine**

□ **Otolaryngology**

□ **Physiatry**

□ **Plastic surgery**

Pulmonology
- □ Pulmonology/asthma
- □ Synagis
- □ Technology-dependent

Rheumatology
- □ General rheumatology
- □ Juvenile idiopathic arthritis

□ **Sleep**

Specialty clinics
- □ 22q Deletion
- □ Aerodigestive
- □ Cerebral Palsy
- □ Craniofacial
- □ Craniofacial Feeding
- □ Craniofacial Speech
- □ Developmental Progress
- □ Epilepsy/Ketogenic Diet
- □ Genetics/Skeletal Disorders
- □ Healthy Lifestyles
- □ Medically Complex
- □ Muscular Dystrophy
- □ Neurofibromatosis
- □ Neurogastroenterology and Motility
- □ Neuro Spine
- □ Pain Relief
- □ Pelvic and Anorectal
- □ Spasticity
- □ Spina Bifida
- □ Strong4Life
- □ Tuberous Sclerosis
- □ Vascular Anomalies
- □ Other

If other, specify: _____

_____

Indicate preferred provider and reason for preference, if applicable: _____

_____

Fax relevant clinic notes, patient demographics and imaging/diagnostic tests to 404-785-9111.

Was the patient's diagnostic testing (related to this referral) performed at Children's? □ Yes □ No
If yes, please do not fax these records.