Referral Order Form
Telemedicine Services

Today's date/time:

☐ **Referral for New Patient consult**
**Good for one year per specialty

☐ **Referral renewal for follow up appointments.**

(Please print)
Patient's name ______________________________
First Middle Last

Patient's Date of Birth ______________ **Patient's Sex:** ☐ **Male** ☐ **Female**

Reason for Referral/presenting Problem ______________________________

Date of Injury/Incident (if applicable): ______________________________

Specialist needed :
☐ Aerodigestive
☐ Allergy/Immunology
☐ Hepatology
☐ Interventional Radiology
☐ Nephrology
☐ Neurology (Keto)
☐ Otolaryngology
☐ Pulmonology
☐ Strong4Life
Other:
____

Preferred Specialist (if any?): ☐ None

Preferred Presenting Site (in any?): ☐ None

Language that family speaks: ☐ **English** ☐ **Spanish** **Other:** ______________________

Guardian's name ______________________________
First Last

City, State ______________________ **County** ______________
**** If non-biological parent accompanies patient to the appointment either legal guardianship papers or a letter of consent is required.**

Daytime Phone #
( )
☐ **Home** ☐ **Cell** ☐ **Work**
Alternate Phone #
( )
☐ **Home** ☐ **Cell** ☐ **Work**

Referral made by:

____
Printed Physician Name

______________________ __________
Signature Time

Referring Contact Information:

____
Address
____
City State Zip
____
Date
____
Phone # Fax #

☐ Referring Physician is the child's Primary Care Physician

***** Please send the most recent History and Physical (completed within the last year) along with this form.**
***** Your telemedicine appointment is not final until the parent/ guardian has called 404-785-KIDS to confirm.**

Working Together for Better Care

www.choa.org/telemedicine **Phone 404-785-KIDS/1-800-785-DOCS Fax 404-785-5855**

Patient Appointment: Date ______________ Time __________ Dr ______________________ Site ______________________________