REQUEST FOR CONSULTATION OR TRANSFER OF CARE

□ Blank Adolescent Clinic *515-241-8336 Fax 515-241-6465*
□ Blank Developmental Clinic 515-241-3434 Fax 241-3290
□ Blank Diagnostic Clinic 515-241-8732 Fax 241-6466
□ Blank Endocrinology Clinic 515-241-6500 Fax 515-241-8911
□ Blank Gastroenterology Clinic 515-241-6542 Fax 515-241-8789
□ Blank Orthopaedic Clinic 515-241-7207 Fax 515-241-7217
□ Blank Infection Diseases Clinic 515-241-8300 Fax 515-241-6466
□ Blank Pediatric Clinic (Primary Care) 515-241-8923 Fax 515-241-6497
□ Blank Psychiatry Clinic 515-263-5153 Fax 515-263-5158
□ Blank Pulmonology Clinic 515-241-6548 Fax 515-241-8795
□ Blank Surgery Clinic 515-241-6546 Fax 515-241-8939

Dx/Reason for Referral (Clinical Question): ____

******For Emergent/STAT or Urgent referrals, please call and ask to speak to a physician regarding a stat consult to ensure this is processed in a timely manner******

Please complete all sections:

Referral is being REQUESTED:
□ Emergent/STAT***
□ Urgent (within 48 hours)
□ Routine

Service/Relationship:
□ Initial consult only
□ Diagnosis Test only
□ Specific Treatment/Procedure
□ Specialty care only (initial consult or one-time services)
□ Ongoing treatment as needed
□ Co-Management of Primary Care Services
□ Transfer to Temporary Primary Care
□ Transfer to Temporary Long Term Care

Records: (Appointment will not be scheduled until all records have been received including PCP's care plan, prior consults, prior imaging, EEG, VEEG, labs, etc.)
____ Records in EPIC
____ Fax: Labs/MRI/EEG or other imaging to 515-241-6533
____ If needed, please obtain ROI for other facilities recently visited

***** INTERPRETER NEEDED □ No □ Yes, language** ___________________________

PATIENT: ____ **DOB**: _______________ **M F**
Social Security # of patient: _______-____-________
Address: ____
____
Home Phone: _____________________________ Cell Phone: _______________________________
e-mail address: ___________________________
Mom/Guardian Name: _______________________________ (W): ___________________ (Cell): ___________
Dad/Guardian Name: ________________________________ (W): ___________________ (Cell): ___________
BILLING (Responsible Party): Name: _________________________ DOB: ___________ SS #: ______-______-_______
INSURANCE: ____ ***PLEASE SEND COPY OF CARD**
Group #: _______________________ Policy #: ______________ MCO/XIX or Medicaid #: ______________________
Secondary Insurance: ____ ***PLEASE SEND COPY OF CARD**
Group #: ______________________ Policy #: ________________ MCO/ XIX or Medicaid #: ______________________

PRIMARY PROVIDER: __________________________________ Phone:__________________ Fax: _________________
REFFERING PROVIDER: ________________________________ Phone:__________________ Fax: _________________
Clinic Address: ____ Contact: ______________________

Clinic Use Only:
Date Referral Received: _______________ *(initial)* ______ **Date Sent to Physician Review:** _______________ *(initial)* ______
Reviewed by: __________________________________ **Date Reviewed:** ________________ *(initial)* __________
Please Schedule Patient:
□ Urgent, today (notify MD if unable to schedule)
□ ASAP (notify MD if unable to schedule in 1 week)
□ Routine
□ At parent's convenience

□ **Additional information needed:** ____
□ **Request EEG for appt:** ______________________ □ Other: ____

Notes: