BLANK Pediatric Endocrinology Clinic

CEDAR RAPIDS

REQUEST FOR CONSULTATION OR TRANSFER OF CARE

Phone: (515) 241-6500 - Fax: (515)241-8911

Referring Provider:

DX/Reason for Request: _____

_____ Consult only and return patient

_____ Transfer for management of this particular problem only and return patient upon conclusion of care

TIMING: ☐ First Available

_____ Please call if transfer to another provider becomes necessary

_____ Schedule any required pre-op exam with our office

_____ **Records available in AllScripts**

_____ **FAX RECORDS TO: Endocrinology Clinic fax - (515) 241-8911**

INFORMATION NEEDED:

- ■ Growth Chart
- ■ Laboratory Studies
- ■ X-Ray Film or CD
- ■ Current Treatment Plan
- ■ Office Notes
- ■ If Bone Age done, need actual film or CD sent to our office
- ■ Procedures

Clinical/Clerical Staff:

******INTERPRETER NEEDED?*** ☐ Yes ☐ No Language_____

PATIENT: _____ **DOB:** _____ M F
(First) (MI) (Last)

Social Security # of Patient_____-_____- _____

Address: _____

_____

Home Ph:_____ Daytime Ph: _____

DAD / Domestic Partner: Name:_____(W)_____(cell)_____

MOM / Domestic Partner: Name:_____(W)_____(cell)_____

BILLING: (Responsible Party) Name: _____
(First) (MI) (Last)

Billing: DOB:_____ SS #:_____-_____- _____

INSURANCE: _____ ****PLEASE SEND COPY OF CARD****

Group #: _____ Policy #:_____

XIX or MEDIPASS # _____ Medipass: _____

Medipass Referral # _____ From DOS thru_____/Global

Secondary Insurance:_____ ****PLEASE SEND COPY OF CARD****

Group #: _____ Policy #: _____

PRIMARY PROVIDER: _____ Phone: _____
(Primary Provider is listed on insurance screen)

Fax: _____

REFERRING PROVIDER: _____
(Referring Provider is listed on appointment screen)

Phone:_____ **FAX:** _____ **Contact:** _____

CLINIC ADDRESS: _____

- DATE REFERRAL RECEIVED:_____ Initial _____
- DATE APPOINTMENT COMMUNICATED TO PARENTS:_____ Initial _____
- DATE APPOINTMENT COMMUNICATED TO PROVIDER:_____ Initial _____