Children's National Medical Center®

SPECIALTY REFERRAL REQUEST FORM

DATE OF REQUEST:

FAX FORM TO 202-476-7651

PATIENT INFORMATION

PATIENT NAME:		PATIENT DATE OF BIRTH:	
PATIENT ADDRESS:		PATIENT CITY, STATE, ZIP:	
PARENT NAME 1:		PARENT NAME 2:	
HOME PHONE:	CELL:	HOME PHONE:	CELL:
WORK PHONE:		WORK PHONE:	
EMAIL:		EMAIL:	

REFERRING PHYSICIAN INFORMATION

REFERRING MD NAME:	PRACTICE NAME:
PRACTICE ADDRESS:	

Please indicate your preferred follow-up communication method(s).

☐ OFFICE PHONE:	☐ CELL PHONE:
☐ OFFICE FAX:	☐ EMAIL:

REQUESTED SPECIALTY CONSULTATION *(to be completed by referring provider)*

SPECIALTY DEPARTMENT:	PREFERRED SPECIALIST: ☐ FIRST AVAILABLE
PRIORITY: ☐ PRIORITY ☐ ROUTINE (ROUTINE APPT REQUESTS ARE USUALLY AVAILABLE WITHIN A MONTH; PRIORITY APPTS ARE AVAILABLE FOR MEDICAL NECESSITY ONLY)	PREFERRED LOCATION: ☐ FIRST AVAILABLE

BRIEF HISTORY, SYMPTOMS, PERTINENT LAB RESULTS, WORKING DIAGNOSIS, SPECIAL NEEDS:

REASON FOR REFERRAL *(Please check all that apply)*	PREFERRED ROLE *(Please check all that apply)*
☐ Clarify or establish diagnosis	☐ Resume full management after consultation
☐ Advice on management	☐ Co-manage patient with specialist
☐ Diagnostic or therapeutic procedure	☐ Transfer on-going care of patient to specialist
☐ Other:	☐ Decide roles after consultation

FULL CONSULTATION NOTE WILL BE AVAILABLE AT www.ChildrensNational.org/Gateway.

Print form

DM 12-2012