REFERRAL REQUEST FOR CONSULTATION

BEACON MEDICAL GROUP
PEDIATRIC MULTI-SPECIALTY

BEACON CHILDREN'S HOSPITAL

PEDIATRIC MULTI-SPECIALTY CLINIC **PH: 574-647-2550 FAX: 574-647-1140**

- ☐ Pediatric Pulmonary
- ☐ Pediatric Infectious Disease
- ☐ Pediatric Gastroenterology
- ☐ Pediatric Neurology
- ☐ Behavioral & Developmental Pediatrics
- ☐ Pediatric Endocrinology
- ☐ Sleep Medicine
- ☐ Feeding Team Evaluation

PEDIATRIC HEM / ONC CLINIC **PH: 574-647-6892 FAX: 574-647-6895**

- ☐ Pediatric Hematology / Oncology

DATE OF REFERRAL _____

PATIENT INFORMATION:

First Name:_____ Last Name: _____ DOB: _____

Address: _____ Gender: ☐ Male ☐ Female

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work / Other: _____ Preferred Language: _____

Insurance: _____ **Send *copy of insurance card & request PA if appl.***

Guardian: _____ Relationship:_____ DOB_____

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REASON FOR REFERRAL: (Please explain signs & symptoms experiencing)

PLEASE FAX THE FOLLOWING APPLICABLE RECORDS WITH THIS REQUEST:

- **FOR ALL REFERRALS:** Demographics, Front & Back of Insurance Card, Pertinent clinic notes, Labs, immunizations
- **NEUROLOGY / GASTRO / DEV PEDS / ENDOCRINE / HEM-ONC:** Growth Charts, EEG, CT, MRI, (if patient had).
- **PULMONARY:** The patient's most recent chest x-ray
- **DEV PEDS / BEHAVIORAL / PSYCHOLOGY:** Any Therapy evals, IFSP, School psycho social evaluations & IEP

REFERRING PHYSICIAN INFORMATION:

Name of Referring Physician: _____

Name of PCP, if different than the referring physician: _____

Name / Title of person filling out this Referral form: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

THIS REFERRAL WILL NOT BE PROCESSED IF INFORMATION IS NOT COMPLETE. ***Revised: 09.18.19***