UL Physicians

University of Louisville Physicians

Request for Referral of Pediatric Specialty Groups

PATIENT INFORMATION

DATE OF REFERRAL:	REFERRING OFFICE CONTACT NAME AND NUMBER:	
PATIENT'S LAST NAME:	FIRST:	MIDDLE:
BIRTHDATE:	M ☐ F ☐	
INSURANCE NAME:	ID #:	
STREET ADDRESS:	CITY:	STATE: ZIP CODE:
HOME PHONE: ( )	CELL PHONE: ( )	WORK PHONE: ( )
WILL FAMILY NEED AN INTERPRETER? YES ☐ NO ☐	PRIMARY LANGUAGE SPOKEN:	
IS THIS CHILD IN FOSTER CARE? YES ☐ NO ☐ If YES, complete Case Manager Info	CASE MANAGER (CM) NAME: (last, first)	Phone:

PARENT/LEGAL GUARDIAN INFORMATION

MOTHER'S NAME: LAST	FIRST:	MI
FATHER'S NAME: LAST	FIRST:	MI
LEG. GUARDIAN'S NAME: LAST	FIRST:	RELATION TO CHILD:

LEG. GUARDIAN'S ADDRESS IF DIFFERENT FROM CHILD'S: STREET ADDRESS

CITY:	STATE:	ZIP CODE:	HOME PHONE: ( )	CELL PHONE: ( )

SPECIALTY REQUESTED: (FAX NUMBERS LISTED BELOW)

☐	ACUPUNCTURE	502-588-2551	
☐	ALLERGY	502-588-9535	
☐	CARDIOLOGY	502-589-1256	
☐	ENDOCRINOLOGY	502-588-3401	
☐	WENDY NOVAK DIABETES CTR.	502-588-3401	
☐	GASTROENTEROLOGY	502-588-9513	
☐	HEMATOLOGY/ONCOLOGY	502-588-9536	
☐	IMMUNODEFICIENCY CLINIC	502-588-2334	
☐	INFECTIOUS DISEASE	502-588-2334	
☐	NEONATAL FOLLOW UP	502-588-0984	
☐	NEPHROLOGY	502-588-7712	
☐	NEUROLOGY	502-588-7852	
☐	PSYCHIATRY	502-588-0801	
☐	PULMONOLOGY	502-588-7712	
☐	RHEUMATOLOGY	502-588-9554	
☐	SLEEP	502-588-2221	
☐	UROLOGY	502-588-9537	
☐	WCEC DEVEL./GENETICS	502-588-9534	
☐	UofL AUTISM CENTER	502-588-0721	

Does this patient need an urgent appointment? _____Yes _____No

Do you want this patient scheduled with a specific provider? _____Yes _____No If so, with whom?_____

(Note: Requesting a specific provider may cause delays in appointment scheduling.)

REASON FOR REFERRAL:

Presenting Concerns: **PLEASE ATTACH LAST H&P AND ANY TEST RESULTS**

Current Diagnosis / Rule-Out Diagnosis: (if any) **PLEASE ATTACH COPY OF REFERRAL IF NEEDED**

REFERRING PHYSICIAN INFORMATION:

Are you the Patient's Primary Care Physician? Yes ☐ No ☐		If no, list PCP Name and Phone Number Below.	
PCP Name:		PCP Phone Number:	Doctor's NPI #
Referring Physician's Name (Printed)		Address:	
City	State	Zip Code	County
Group Name			
Office Phone	Fax Number	Private Physician #:	Email Address:

OFFICE USE ONLY:

Date and Time of Appointment:	Provider:

Date Revised: 3/16/2016