CHILDREN'S SPECIALTY CARE

PATIENT REFERRAL FORM

FAX YOUR REFERRALS TO 510-995-2956 OR 510-995-2955.

DATE ____________________ **SPECIALTY DEPARTMENT:** ____________________

REFERRED TO (OPTIONAL) ____________________

PREFERRED APPOINTMENT LOCATION:
☐ Brentwood ☐ Larkspur ☐ Pleasanton ☐ Walnut Creek ☐ Oakland ☐ Next available-any location

PATIENT INFORMATION

Patient's First Name ____________________

Last Name ____________________

DOB ____ / ____ / ____ Gender ☐ Female ☐ Male

Parent/Guardian Name ____________________

Relationship ____________________

Address ____________________

Daytime Phone (______) ____________________

Alternate Phone (______) ____________________

Interpreter needed? ☐ No ☐ Yes

If so, what language? ____________________

MEDICAL INFORMATION

Diagnosis/Reason for referral ____________________

____

____

Is this an urgent referral? ☐ No ☐ Yes If yes, please call the department if your patient requires acute care.

Reason for urgent referral ____________________

____

____

PATIENT HISTORY

Brief History / Work Up ____________________

____

____

Previous visits to Children's Hospital & Research Center Oakland for this problem? ☐ No ☐ Yes

INSURANCE INFORMATION

Health Plan ____________________

Authorization # ____________________

Group # ____________________

Member ID ____________________

Secondary Insurance, if any ____________________

REFERRING MD CONTACT INFORMATION

Referring MD ____________________

Best way to reach me is by ☐ Phone ☐ Fax ☐ Pager

Phone (______) ____________________

Fax (______) ____________________

Office Name/Location ____________________

Pager ____________________

ATTACHMENTS

Please note: Sending this information helps us give your patient the most effective care.

☐ Medical Record Notes
☐ Growth Curves
☐ Pertinent Operative Note
☐ Results of Diagnostic/Imaging Studies
☐ Pertinent Lab Studies

If lab or imaging studies have been completed at Children's, we will retrieve the results. You do not have to send them. Please call if you would like to speak with the consulting physician prior to the appointment.

Diagnostic Imaging
747 52nd St. #210, 2nd Floor
Oakland, California 94609-1809
Phone: (510) 428-3410
Fax: (510) 995-2955

PATIENT NAME: ____________________ **REFERRING PHYSICIAN:** ____________________
DOB: ____________________ **PHYSICIAN SIGNATURE:** ____________________
PATIENT CONTACT #: ____________________ **DATE:** ____________________
OAKLAND ☐ **WALNUT CREEK** ☐ **INS:** ____________ **AUTH #:** ____________

DIAGNOSTIC IMAGING POLICY: MUST HAVE COMPLETE ORDER AND DEMOGRAPHICS/REOUEST FORM TO SCHEDULE DIAGNOSTIC IMAGING EXAMS. NO AUTH/NO TEST & NO ICD 9 CODE/NO TEST

PATIENT HISTORY/DIAGNOSIS: Please include signs, symptom and/or known diagnosis **(no R/O)**	**SPECIAL INSTRUCTIONS:** STAT PHONE REPORT Y ☐ or N ☐ PHONE /PAGER:

General Diagnostic XRAY Plain Film

Finger	Lt ☐	Rt ☐	Toes	Lt ☐	Rt ☐	Chest 1view	☐	C Spine AP/LAT	☐	Skull 2 views	☐
Hand	Lt ☐	Rt ☐	Foot	Lt ☐	Rt ☐	Chest 2view	☐	C Spine Lat Only	☐	Skull 3 views	☐
Wrist	Lt ☐	Rt ☐	Heel	Lt ☐	Rt ☐	Chest w/decub	☐	C Spine 3 view	☐	Facial Bones	☐
Forearm	Lt ☐	Rt ☐	Ankle	Lt ☐	Rt ☐	Ribs	☐	C Spine w/Flex-Ext	☐	Nasal Bones	☐
Elbow	Lt ☐	Rt ☐	Tib/Fib	Lt ☐	Rt ☐	KUB	☐	T Spine AP/LAT	☐	Sinus Series	☐
Humerus	Lt ☐	Rt ☐	Knee	Lt ☐	Rt ☐	Abd w/decub	☐	L Spine AP/LAT	☐	Mandible	☐
Shoulder	Lt ☐	Rt ☐	Finger	Lt ☐	Rt ☐	Pelvis	☐	L Spine w/Flex-Ext	☐	Special View	☐
			Hip	Lt ☐	Rt ☐	Skeletal Survey	☐	Scoliosis AP Only	☐		
			Bone Age					Scoliosis AP/LAT	☐		
								Neck Soft Tissue	☐		
								Neck 2 view	☐		

OTHER X-RAY NOT LISTED ABOVE:

Fluoroscopy		**Ultrasound**		**Nuclear Medicine**		**CT** General anesthesia Y or N			**MRI** General anesthesia Y or N		
UGI	☐	Abdomen	☐	DMSA	☐		w/o	w/		w/o	w/
UGI w/SBFT	☐	Abdomen Limited	☐	Galium Scan	☐	Head	☐	☐	Brain	☐	☐
Esophagram	☐	Chest	☐	Gastric Emptying	☐	Maxofacial	☐	☐	C-Spine	☐	☐
Video Swallow	☐	Head	☐	GFR	☐	Sinus	☐	☐	T-Spine	☐	☐
Contrast Enema	☐	Hip	☐	GI Bleed	☐	Orbits	☐	☐	L-Spine	☐	☐
VCUG	☐	Neck	☐	Hida Scan	☐	Neck	☐	☐	Chest	☐	☐
Broviac Study	☐	Orbit	☐	Mag 3	☐	Chest	☐	☐	Abdomen	☐	☐
Fistula Study	☐	Pelvic	☐	Lung Perfusion Scan	☐	Abdomen	☐	☐	Pelvis	☐	☐
		Renal	☐	Liver/Spleen Scan	☐	Pelvis	☐	☐	Upper Extremity	☐	☐
		Scrotum	☐	Meckles Scan	☐	Cervical	☐	☐	Lower Extremity	☐	☐
		Spine	☐	RNC	☐	Thoracic	☐	☐	MRA	☐	☐
		Thyroid	☐	Whole Body Scan	☐	Lumbar	☐	☐			
		Extremity	☐	Limited Body Scan	☐	Scanogram	☐	☐			
						Upper Extremity	☐	☐			
						Lower Extremity	☐	☐			
						Temporal Bones	☐	☐			

OTHER PROCEDURES NOT LISTED ABOVE: