CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

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.

CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

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: