UCSF Benioff Children's Hospital Oakland

PATIENT REFERRAL FORM

747 52nd St., Oakland, CA 94609 • 510-428-3000 • www.childrenshospitaloakland.org

★ **Information is required to proceed with scheduling.**

Fax your referrals to 510-985-2202.

★ **Date**_____ ★ **Specialty Department** _____

Referred to (optional)_____

Preferred location: ☐ Brentwood ☐ Larkspur ☐ Oakland ☐ San Ramon ☐ Walnut Creek ☐ Next available (Any location)

PATIENT INFORMATION

★ **Patient First Name** _____

★ **Patient Last Name** _____

★ **DOB** _____/_____/_____

★ **Gender** ☐ Female ☐ Male ☐ Other_____

★ **Phone** ☐ Home ☐ Mobile ☐ Work (_____) _____

★ **Phone** ☐ Home ☐ Mobile ☐ Work (_____) _____

Interpreter needed? ☐ No ☐ Yes

If yes, what language? _____

Parent/Guardian Name _____

DOB _____/_____/_____ Relationship_____

Street Address _____

City_____State_____Zip _____

REFERRING MD CONTACT INFORMATION

★ **Referring MD** _____

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

★ **Phone** (_____) _____

Fax (_____)_____

Pager (_____)_____

Office Name _____

Office Street Address _____

City_____State_____Zip _____

MEDICAL INFORMATION

★ **Diagnosis/Reason for referral**_____

_____

_____

_____

_____

★ Please send medical records supporting diagnosis/reason for referral:

☐ Clinical notes

☐ Growth charts

☐ Imaging

☐ Labs

INSURANCE INFORMATION

★ **Is insurance info attached?** ☐ Yes ☐ No

Subscriber Name _____

DOB _____/_____/_____

Health Plan _____

Authorization # _____

Group # _____

Member ID_____

Secondary Insurance, if any_____

_____