PRINT CLEAR FORM

Valley Children's HEALTHCARE

Valley Children's Healthcare **Outpatient Referral Form**

URGENT
844-466-9451 FAX

ROUTINE
559-353-8888 FAX
valleychildrens.org/refer eReferral

Thank you for referring your patient to Valley Children's. To expedite appointment scheduling, please provide the following:

- Send all pertinent records including lab and radiology reports, EKG's and EEG's, etc.
- Attach a signed order for all diagnostic testing such as radiology services
- Provide a prescription signed by the referring MD for PT, OT, Speech and Audiology referral

Note: For Urgent Hematology/Oncology patients, please call 559-353-5460 to speak directly to a physician before faxing referral.
For questions about the status of a referral, please call 559-353-8800.
For patients and families checking on the status of a new referral, please call 559-353-8899.

Today's date _____

Practice/Service Requested _____

Reason for consultation with this Service _____

Date of Injury or onset of illness _____

For Diagnostic Services, test requested _____

Indication for test _____

Patient Last Name_____ First _____MI _____

DOB_____Sex ❑ M ❑ F

Address _____City _____ Zip _____

New to Valley Children's? ❑ Yes ❑ No Please enter Valley Children's MR# if available: _____

Who should we call to schedule this appointment? Last name _____First _____

Relationship of above person to patient ❑ Parent ❑ Guardian

Contact #s _____ _____ _____ _____

Preferred: ❑ home ❑ work ❑ cell Other: ❑ home ❑ work ❑ cell Other: ❑ home ❑ work ❑ cell Other: ❑ home ❑ work ❑ cell

Primary language _____ Interpreter needed? ❑ Yes ❑ No

Referring Physician _____ Phone _____ Fax _____

Address _____ City _____ Zip_____
(To ensure accurate delivery of visit documentation)

Contact at referring physician's office_____

Primary care physician _____ Phone _____ Fax
(If different from referring physician)

Guarantor_____ DOB_____

Insurance Information (send copy of insurance card and authorization for consultation and treatment or diagnostic services)

Insurance _____**Subscriber name** _____

Subscriber or CIN # (required) _____Authorization #_____

Effective date _____Number of visits _____ Expiration date _____

Employer_____

CCS Coverage ❑ Yes ❑ No CCS DX _____

Your patient will be contacted to schedule the appointment at a time which is convenient and, if necessary, to review insurance coverage and obtain additional demographic information.

If we are unable to provide the requested service or reach your patient to schedule the appointment, we will notify your office.