PRINT EMAIL CLEAR FORM

Valley Children's HEALTHCARE

9300 Valley Children's Place, Madera, CA 93636

valleychildrens.org

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

Routine Referrals Only

NOT FOR URGENT OR EMERGENT REFERRALS

If this appointment is urgent or emergent please call the practice/service directly

Phone (559) 353-8800 or out of area **(888) 824-5439 • FAX (559) 353-8888**

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

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 Children's? ☐ Yes ☐ No Please enter 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)

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. When an appointment has been scheduled for your patient, you will be notified by fax of the appointment date/time.

If we are unable to provide the requested service or reach your patient to schedule the appointment, we will contact your office to discuss the referral.
If you have questions regarding this referral, please contact the practice directly or call (559) 353-8800.