

Direct Physician Referral

REFERRED TO: _____ Date: _____
 Phone #: (_____) _____ Fax #: (_____) _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
 AKA: _____ MR#: _____
 Address: _____ APT #: _____
 City: _____ ZIP: _____ Phone #: (_____) _____
 Legal Guardian/Caregiver Name: _____ Relationship: _____
 Cell/Work #: (_____) _____ Emergency #: (_____) _____
 Language Spoken: English _____ Spanish _____ Other _____

REFERRED FROM:

Dr. _____ Specialty: _____
 Contact Person: _____ Office Hours: _____
 Phone #: (_____) _____ Fax #: (_____) _____
 Reason for referral: _____

 Medical records/clinical information: Attached _____ Will be sent with authorization: _____

INSURANCE/AUTHORIZATION INFORMATION:

Insurer: _____
 Insured: _____ Relationship to patient: _____
 Policy #: _____ Contact Number: (_____) _____
 Authorization: Not needed: PPO _____ CCS Center Care # _____
 Authorization Attached: _____ Requested on: _____ and will send upon receipt: _____

OTHERS INVOLVED IN CHILD'S CARE:

PCP: _____ Phone #: (_____) _____
 Address: _____ Suite#: _____
 Fax #: (_____) _____ Office Contact: _____

APPOINTMENT MADE:

Date: _____ Time: _____
 Family Aware: Message Left at (_____) _____ on _____
 Spoke with: _____ Relationship: _____