

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: _____	