

**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: \_\_\_\_\_