Miller Children's Hospital
MEMORIALCARE MEDICAL CENTERS

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:_____