

Pediatric Clinic/Service to which you are referring:

Today's Date: _____

GAINESVILLE:	Allergy	Endo	GI	Genetics	Hem/Onc
	Immunology/Rheumatology	Infectious Disease	Nephrology	Neurology	Pulmonary
TALLAHASSEE:	Genetics	GI	ID	Hem/Onc	Neurology
OCALA:		GI		Neurology	Pulmonary
FOR SPECIALTIES/SERVICES NOT LISTED ABOVE, PLEASE CALL 352-265-0111					

Physician Preference (if applicable): _____

Consultation *(Evaluation and recommendation to be used by referring physician for management of care w/ or w/o co-management by specialist.)*

Transfer of Care *(Evaluation and subsequent care management by specialist.)*

Current Diagnosis: _____

Patient Information:

Name (Last, First MI):		DOB:	Choose One: MALE FEMALE	SSN:
Mailing Address:		City:	State:	ZIP:
Guardian/Guarantor:		Relationship:		
Preferred Phone #:	Alternate Phone#:	IS INTERPRETER/TRANSLATOR NEEDED? If yes, what language?		YES NO

Insurance Information:

Insurance Company:		Policy #:	Group #:
Subscriber Name (Last, First MI):		DOB:	Choose One: MALE FEMALE
Employer:	*Authorization #:		
Ins Phone #:	Auth Exp. Date:	CMS Patient: YES NO	

*Please include authorizations for: Capital Health (CHP), Cigna (must have Dx), CMS Title XXI out of district (must have name), Coventry, First Coast Advantage, First Health, FL Health Care (Healthy Kids), Healthcase/Staywell/Wellcare, Medipass, Prestige, Ped-I-Care, Tricare Prime.
Medicaid HMOs may not be accepted.

Referring Physician Information:

Name (Last, First MI):		Contact:
Mailing Address:		City: State: ZIP:
Phone #:	Fax #:	

PLEASE REFER TO PAGE 2 FOR A LIST OF DOCUMENTS/INFORMATION TO INCLUDE WITH REFERRAL

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With this referral, please include the following items per the clinic/service to which you are referring. Please check to indicate that item is attached. Please write "N/A" if item is not available.

If a second opinion is being sought, the previous specialist's dictation and work-up must be included.

ALLERGY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports

GASTROENTEROLOGY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports
☐ History & Physical
☐ Growth Charts

HEMATOLOGY/ONCOLOGY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports

INFECTIOUS DISEASE

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports
☐ Immunization Records

For recurrent fevers or fevers of unknown origin:

☐ CBC w/diff/platelet
☐ CMP
☐ ESR
☐ CRP
☐ EBV IgG/M
☐ CMV IgG/M
☐ ANA
☐ RF
☐ HIV
☐ Urinalysis w/ culture
☐ Blood culture w/ fevers
☐ PPD

PULMONARY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports

ENDOCRINOLOGY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports
☐ Growth Charts
☐ Bone Age Studies
☐ Lipid Panel
☐ Glucose, Insulin Levels

GENETICS

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports

IMMUNOLOGY/RHEUMATOLOGY

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports
☐ Immunization Records

NEPHROLOGY/RENAL

☐ Clinic Notes
☐ Lab Work
☐ Diagnostic Radiology Reports
☐ Urinalysis
☐ Renal U/S

NEUROLOGY

☐ Office/Clinic Notes (last 2 visits)
☐ Lab Work (last 12 months)
☐ Brain/Imaging Reports (Films/CDs may be requested prior to appt at Neurologist's discretion)
☐ EEG, EMG, EP, PSG Reports
☐ ED/Hospital Discharge Summaries