dell children's
medical center of central texas
A member of the Seton Healthcare Family

# SPECIALTY REFERRAL FORM

- ☐ Allergy/Immunology
- ☐ Craniofacial/Plastics
- ☐ Dentistry
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Genetics
- ☐ Hematology/Oncology
- ☐ Infectious Disease
- ☐ Nephrology
- ☐ Neurology
- ☐ Ophthalmology
- ☐ Oral/Maxillofacial Surgery
- ☐ ENT
- ☐ Physical Medicine & Rehabilitation
- ☐ Pulmonology
- ☐ Rheumatology
- ☐ Other_____

## PATIENT INFORMATION:

PATIENT NAME: _____

SEX:_____ DATE OF BIRTH:_____

PARENT NAME:_____

ADDRESS:_____ CITY/STATE/ZIP_____

PHONE NUMBER 1:_____ PHONE NUMBER 2:_____

INSURANCE:_____

GUARANTOR INFORMATION:_____

## REFERRAL INFORMATION:

DATE OF REFERRAL: _____

REFERRING PHYSICIAN (PLEASE PRINT:)_____

PHYSICIAN TELEPHONE:_____ PHYSICIAN FAX:_____

REASON FOR REFERRAL:

- ☐ EVALUATE AND TREAT
- ☐ CONSULT
- ☐ OTHER – ADDITIONAL COMMENTS: _____

_____

_____

## PATIENT SHOULD BE SEEN WITH OPTIONS:

- ☐ STAT* (1-2 Weeks)
- ☐ URGENT (1-3 Month)
- ☐ NEXT AVAILABLE (4-6 Months)

by a:

- ☐ MD ONLY
- ☐ NP or MD

*Please note if referral request is STAT, please contact office directly.

**In order to complete the referral process, please do the following:**

- ✓ COMPLETE THIS REFERRAL FORM
- ✓ DESIGNATE SPECIALTY
- ✓ INCLUDE PHYSICIAN NOTES/MEDICAL RECORDS
- ✓ RECENT LAB WORK AND/OR RADIOLOGY RESULTS
- ✓ COPY OF INSURANCE CARDS
- ✓ PRIOR AUTHORIZATION IF REQUIRED