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

FRACTURE CLINIC

REFERRAL FORM FOR SPECIALTY CARE CENTER

MARNIE PAUL SPECIALTY CARE CENTER
PHONE: 512-324-0137 • FAX: 512-406-6520

TO: APPOINTMENT DESK **FAX TO: 512-406-6520** **NUMBER OF PAGES:** _____

FROM: _____

PHONE: _____ **FAX:** _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Contact Name: _____ Relationship to Patient: _____

Contact Telephone: cell _____ home _____ work _____

Patient Address: _____

PHYSICIAN INFORMATION

Referring Physician (*full name*): _____ ❑ MD ❑ DO

Primary Care Physician (*if different from referring physician*): _____

Physician Telephone: _____ Physician Fax: _____

MEDICAL INFORMATION

Diagnosis: _____ ICD code: _____

Reason for Referral: _____

Insurance Company: _____ ❑ HMO ❑ PPO

ID #: _____ Group Number: _____ Authorization #: _____
(If required.)

Area Injured: _____ ❑ Right ❑ Left ❑ Acute ❑ Chronic

Laceration repair? ❑ YES ❑ NO Date: _____

DOI: _____ How: _____

Pop heard? ❑ YES ❑ NO Swelling? ❑ YES ❑ NO

Films? ❑ YES ❑ NO Where/When: _____

MRI? ❑ YES ❑ NO Results: _____

_____ Circle where seen: ER Urgent Care PCP Date: _____
Referring Physician Signature and Date Required

ALL BLANKS MUST BE COMPLETED. PLEASE INCLUDE ANY APPLICABLE HISTORY AND MEDICAL RECORDS