Specialty Referral Request Form

Date Requested: ___________________________

Fax Form To: 202-476-7651			
Patient Information			
Patient Name:		Patient Date of Birth:	
Patient Address:		Patient City, State, Zip:	
Parent Name 1:		Parent Name 2:	
Home Phone:	Cell Phone:	Home Phone:	Cell Phone:
Work Phone:		Work Phone:	
Email:		Email:	
Referring Physician Information			
Referring MD Name:		Practice Name:	
Practice Address:			
Please indicate your preferred follow-up communication method(s) ☐ Office Phone: ____________________ ☐ Cell Phone: __________________________ ☐ Office Fax: ______________________ ☐ Email: _______________________________			
Requested Specialty Consultation (to be completed by referring provider)			
Specialty Department:		Preferred Specialist: First Available	
Priority: ☐ Priority ☐ Routine Routine appointment requests are usually available within a month. Priority appointments are available for medically necessary only.		Preferred Location: First Available	
Brief History, Symptoms, Pertinent Lab Results, Working Diagnosis, Special Needs: .			
Reason for Referral (please check all that apply) ☐ Clarify or establish diagnosis ☐ Advice on management ☐ Diagnostic or therapeutic procedure ☐ Other: ________________________________		Preferred Role (please check all that apply) ☐ Resume full management after consultation ☐ Co-manage patient with specialist ☐ Transfer on-going care of patient to specialist ☐ Decide roles after consultation	

Full consultation note will be available at ChildrensNational.org/Gateway