

Yale Pediatrics A PRACTICE OF THE YALE MEDICAL GROUP

PEDIATRIC SPECIALTY NEW PATIENT FORM

Date: _____

OPTION

If faxing a request, choose option 2 and fax form to number below. If calling to schedule an appointment (203-785-4081), we will fax form to you for confirmation.

- 1 **PHONE OPTION/APPOINTMENT CONFIRMATION:** Your patient has an appointment scheduled with _____ from the _____ service on _____ at _____ AM/PM. Please provide a brief medical history and current medications then fax this form to the appropriate number listed below **ALONG WITH PERTINENT MEDICAL RECORDS.**

SELF-REFERRED PROVIDER REFERRED

- 2 **FAX OPTION/APPOINTMENT REFERRAL:** Please complete this form in its entirety and fax it to the appropriate number listed below **ALONG WITH PERTINENT MEDICAL RECORDS.**

Allergy/Immun	203-737-7635	Heme/Onc	203-737-2228	Respiratory	203-737-7635
Cardiology	203-737-2786	Infect. Diseases	203-785-6961	Rheumatology	203-737-7635
Dev. & Behav.	203-737-1208	Int'l Adopt	203-737-1208	Spina Bifida	203-737-2236
Diabetes	203-764-6748	Hepatology	203-785-3365	Thyroid Center	203-737-5972
Endo/Obesity	203-764-9149	Nephrology	203-737-7635		
GI	203-737-7635	Neurology	203-737-2236		

Patient Name: _____ DOB: _____

Address: _____

Parent/Guardian Name(s): _____

Phone: (Day) _____ (Evening) _____ (Cell) _____

Primary Language if other than English: _____ Interpreter Req: Yes No

Insurance Company Name: _____ ID #: _____

Brief Medical History/Reason For Referral: _____

Hospital Discharge: Yes No If YES, Specialty Consulted In Hospital: Yes No
Medications: _____

Labs/Diagnostic Imaging/Records (Please indicate below records you are faxing with this form)

- | | |
|---|---|
| <input type="checkbox"/> Bloodwork | <input type="checkbox"/> Cardiac Tests |
| <input type="checkbox"/> Stool/Urine | <input type="checkbox"/> Neurologic Testing |
| <input type="checkbox"/> Pertinent Office Records/Growth Charts | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> X-ray/other diagnostic imaging | <input type="checkbox"/> Other (specify): _____ |

PCP/Referring Provider Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail(optional): _____

For Yale Office Use Only

Appt. faxed back to PCP: Date: _____ Initials: _____ Info. sent to parent/guardian: Date: _____ Initials: _____

(To Be Completed For Fax Option Appointment Referrals Only)

Date Received: _____ Appointment Date: _____ Appointment Time: _____

Scheduled Provider: _____ Authorized By: _____

Parent/Guardian Notified: () Yes () No - Conversation: _____ Message: _____ Date: _____ Initials: _____