# Connecticut Children's Specialty Group Referral Form

CONNECTICUTCHILDRENS.ORG

**Connecticut Children's Patient Label**
*for internal use only*

## MEDICAL SPECIALTY

Adolescent Medicine
*P 860.837.7681 F 860.837.5361*

Cardiac Services*
*P 860.545.9400 F 860.545-9410*

Developmental Pediatrics
*P 860.837.5758 F 860.837.5235*

Endocrinology
*P 860.837.6700 F 860.837.6765*

Food Allergy Program
*P 860.545.8514 F 860.545.8661*

Gastroenterology
*P 860.545.9560 F 860.545.8480*

Genetics
*P 860.837.5759 F 860.837.5269*

Hematology/Oncology
*P 860.545.9630 F 860.545.9622*

Infectious Diseases
*P 860.545.9490 F 860.545.9371*

Nephrology
*P 860.545.9395 F 860.545.8422*

Neurology
*P 860.837.7500 F 860.837.7550*

Pain Medicine
*P 860.837.5207 F 860.837.5209*

Physiatry
*P 860.837.6350 F 860.837.5235*

Pulmonary Medicine
*P 860.545.9440 F 860.545.9445*

Rheumatology
*P 860.545.9390 F 860.545.9914*

Suspected Child Abuse & Neglect (SCAN)**
*P 860.837.5890***

**Please call the office if referring a patient under one year of age.*
***Please do not fax referrals to the SCAN program.*
*Please call the department directly at 860.837.5890 to discuss the referral first or request a consultation.*

## SURGICAL SPECIALTY

We will gladly accept either a phone call or a faxed referral form for surgical specialty appointments. Please refer to the list below:

Otolaryngology
*P 860.545.9650 F 860.545.9214*

Neurosurgery
*P 860.545.8373 F 860.545.8233*

Orthopaedics
*P 860.545.9100 F 860.545.9095*

Sports Medicine
*P 860.284.0220 F 860.284.0221*

Surgery
*P 860.545.9520 F 860.545.9545*

Urology
*P 860.545.9520 F 860.545.9036*

## PATIENT INFORMATION

**Patient Name** Last: ______________________ First: ______________ ☐ M ☐ F

**Street Address:** ______________________________________________

**City/State/Zip:** ______________________________ **Date of Birth**: __________

**Preferred Phone:** Home: ____________ Work: ____________ Cell: ____________

**Parent/Guardian/DCF:** ______________________________________________

***If DCF:*** Social Worker name: ______________________________ Phone: ____________

**Interpreter needed:** ☐ Yes ☐ No *If yes, Language:* ______________________________

**Hearing Impaired:** ☐ Yes ☐ No

**This visit is:** ☐ Routine (within 30 days) ☐ Semi-urgent (within 2 weeks)

**URGENT: PLEASE CALL SPECIALTY OFFICE FOR URGENT APPOINTMENTS. REFER TO LISTING ON THE LEFT SIDE OF THIS FORM.**

**Primary Insurance:** ______________________________ **ID:** ______________

**Guarantor:** ______________________________ **Guarantor Date of Birth:** ____________

**Secondary Insurance:** ______________________________ **ID:** ______________

**Guarantor:** ______________________________ **Guarantor Date of Birth:** ____________

### Reason for Referral/If applicable, please include ICD-10 diagnosis code(s).

______________________________________________

______________________________________________

______________________________________________

Please fax this form along with pertinent information/medical records (office notes, test results, growth charts, labs and other diagnostic reports) to the number(s) listed at left. You may include the demographic form from your computer system with this referral.

### REFERRING PROVIDER INFORMATION

**Referring Provider:** ______________________________________________

**Referring Provider Phone:** ______________________________ **Fax:** ______________

**Patient's Primary Care Physician** (if different from referring): ______________________

Is the family aware of the reason for referral? ☐ Yes ☐ No

Would you like a provider to call to discuss this referral prior to visit? ☐ Yes ☐ No

If requesting an MD-only visit, check here ☐ and a physician will return your call.

### COLLABORATIVE CARE

If a co-management protocol is available, please check here to initiate. ☐

Co-Management Plans include a central algorithm, visit templates, and handouts for the PCP and patient/family. Please check here if you used a Co-Management Plan prior to making this referral: ☐

Referral Guidelines outline when and how to refer to Connecticut Children's for certain conditions.

Please check here if you used a Referral Guideline prior to making this referral: ☐

All collaborative care tools are available at ***www.connecticutchildrens.org/clasp***

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