Connecticut Children's

Date of referral:_____

Referral Form

Phone: 833-733-7669 **Fax**: 860-837-9898 **or** 860-545-9502

Medical & Surgical Specialties

Please place a checkmark(s) next to the specialty you are referring your patient to:

- ☐ Adolescent Medicine
- ☐ Aerodigestive Team
- ☐ Cardiac Services
- ☐ Craniofacial Team
- ☐ Developmental Pediatrics
- ☐ EKG only
- ☐ Endocrinology
- ☐ Fetal Care Center
- ☐ Food Allergy
- ☐ Gastroenterology
- ☐ Genetics
- ☐ Hand Surgery
- ☐ Hematology/Oncology
- ☐ Infectious Diseases/Immunology
- ☐ Lead Treatment Program
- ☐ Nephrology
- ☐ Neurology
- ☐ Neurosurgery
- ☐ Ophthalmology
- ☐ Orthopedics/Sports Medicine
- ☐ Otolaryngology (ENT)
- ☐ Pain Medicine
- ☐ Pediatric Surgery
- ☐ Plastic Surgery
- ☐ Pulmonary Medicine
- ☐ Rheumatology
- ☐ Suspected Child Abuse & Neglect
- ☐ Travel Medicine
- ☐ Urology
- ☐ Weight Management

Medical records attached:

Growth chart ☐ **Office notes** ☐ **Labs** ☐ **Radiology** ☐ **Other** ☐

This visit is: ☐ **Routine** (within 30 days) ☐ **Clinically Urgent** (within 2 weeks)

STAT appointment needed (same or next day)?

Please call 833-733-7669 for a required consult.

Multiple appointment coordination needed: ☐ Yes ☐ No

PATIENT INFORMATION

Patient name: (Last)_____ (First)_____

Preferred Name:_____ **Date of Birth**:_____

Sex (Legal): ☐ M ☐ F **Gender Identity:** ☐ M ☐ F ☐ Other _____

Address:_____ City/State/Zip:_____

Phone: (Preferred) _____ (Secondary)_____

Parent/Guardian Name:_____ Relationship:_____

If DCF: Social Worker_____ Phone:_____

Insurance Co. and ID #:_____

Needs interpreter? ☐ Yes ☐ No If yes, what language:_____

REFERRING PROVIDER INFORMATION

Referring provider:_____

Phone:_____ Fax:_____

MD only visit? ☐ Yes ☐ No

Reason for referral:

_____

_____

_____

ICD code:

_____

Questions?

Patients call: *860-545-9000 for scheduling*

Physicians call: *833-733-7669*