



PEDIATRIC PATIENT REFERRAL FORM

OUTPATIENT CLINICS / SPECIALTIES: PH: 574-647-2550 FAX: 574-647-1129

- Dr. Asad Ansari - Pediatric Pulmonary / Sleep Medicine / Infectious Disease
- Dr. Samira El-Zind - Pediatric Neurology
- Dr. Andrew Riggs - Pediatric Endocrinology
- Drs. Luzzi, Bull, Stanley - Behavioral & Developmental Pediatrics
- Dr. Wahaj Zaidi - Pediatric Gastroenterology

100 Navarre Place
Suite 5550
South Bend, IN 46601

HEMATOLOGY / ONCOLOGY CLINIC: PH: 574-647-6892 FAX: 574-647-6895

- Drs. Colleen Morrison / Dr. George Maher - Pediatric Hematology / Oncology

HOSPITALIST / INTENSIVIST SERVICE: PH: 574-647-7275 FAX: 574-647-3696

CALL to admit to Intensivist Service - Drs. Okanlami, Oranu, Akinbile

CALL to admit to Hospitalist Service - Drs. Dutkiewicz, Maher, Rossow, Veselik, Nichols

PATIENT INFORMATION:

First Name: _____ Last Name: _____ DOB: _____

Address: _____ Gender: Male Female

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work / Other: _____ Preferred Language: _____

Insurance: _____ **Please attach a copy & request a PA if needed**

Guardian: _____ Relationship: _____ DOB _____

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REASON FOR REFERRAL: (Please explain details including any established diagnoses)

PLEASE FAX THE FOLLOWING RECORDS WITH THIS REFERRAL:

- PULMONARY / INFECTIOUS DISEASE / SLEEP: Pertinent clinic notes, Lab reports, most recent chest x-ray, immunization record
- NEUROLOGY / GASTRO: Pertinent clinic notes, Lab reports, Growth Charts, if patient has had EEG, CT, MRI
- ENDOCRINOLOGY/ HEM-ONCOLOGY: Pertinent clinic notes, Growth charts, Pertinent lab reports, Immunization record, testing done
- DEV PEDS / BEHAVIORAL: Pertinent clinic notes, Growth Charts, Lab reports, therapy evals, IFSP, School psycho social eval. & IEP

REFERRING PHYSICIAN INFORMATION:

Name of Referring Physician: _____

Name of PCP, if different than the referring physician: _____

Name / Title of person filling out this Referral form: _____

Physician Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

For MPS USE ONLY: **Appt. Date Given:** _____ **Patient Notified:** _____
NP Packet Sent: _____ **Referring Confirmation sent:** _____