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

Craniofacial Team
P 860.545.9360 F 860.545.9365

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***

Weight Management
P 860.837.6717 F 860.837.6702

**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***

CLASP