

Diagnostic Pediatric Clinic CONSULT INTAKE REFERRAL

Referral made on:		Appt Date:		Time:	
HOSPITAL NUMBER		DOB:			
PATIENT NAME:		SEX:	Female / Male (circle one)		
ADDRESS:					
HOME PHONE:		COUNTY:			
MOTHER'S NAME:		Mom's work #			
FATHER'S NAME:		Dad's work #			

REFERRING PHYSICIAN / PRIMARY CARE DOCTOR NAME (Must be child's primary physician for insurance purposes) _____	
REFERRING PHYSICIAN'S ADDRESS: _____	
Phone #:	Fax #:

TYPE OF INSURANCE: If Medicaid, need Primary Care Physician's Information.

PHYSICIAN'S MEDICAID PROVIDER #: _____ (9 DIGITS) _____ (Cert Code)

CHILD'S 12 DIGIT MEDICAID (rid) NUMBER: _____

PRESENTING PROBLEM: (Your response(s) of presenting problems are required for all referrals)

Was there any lab work drawn or any other studies done? YES / NO (circle one)

If yes, please list: _____

Family needs to bring films or scans? YES / NO (circle one)

Growth record (growth chart) recommended: Received? YES / NO (circle answers)

FAX: (317) 944-5630

Riley Hospital for Children

MSA1 – CLINIC PHONE: (317) 944-2801

Revised 2//16/2011