Children's Physician Group

Children's℠
Healthcare of Atlanta

Provider referral form

Complete this form and fax it to 404-785-9111. Use one form for each patient.

<u>If the patient needs to be seen within the next week, call 404-785-DOCS (3627) and do not fill out this form.</u>

_____
Today's date

_____
Referral form completed by

_____
Direct contact phone number

_____
Email

Preferred method of communication for referring office (choose one):
□ Phone □ Email

□ **Urgent** □ **Non-urgent**

Patient's name: _____

Patient's date of birth: _____

Patient's gender: □ Male □ Female

Parent/guardian's name: _____

Cell phone: _____

Alternate phone: _____

Interpreter required: □ Yes □ No
If yes, provide the language: _____

Referring provider's name: _____

Office phone: _____

Office fax: _____

Referring provider's status with patient: □ PCP □ Not PCP

PCP name: _____

PCP phone: _____

Reason for referral: _____

_____

Specialty needed (choose one):

Allergy and Immunology
- □ Allergy
- □ Immunology

□ **Apnea**

□ **Cardiology: Pulmonary Hypertension**

□ **Cardiothoracic Surgery**

□ **Child Protection**

□ **Craniofacial Surgery**

□ **Cystic Fibrosis**

□ **Dentistry and Orthodontics**

□ **Diabetes**

□ **Endocrinology**

Gastroenterology
- □ Eosinophilic and allergic GI diseases
- □ Feeding (IEAT)
- □ General gastroenterology
- □ Growth problems
- □ Inflammatory bowel disease (Crohn's and ulcerative colitis)
- □ Intestinal rehabilitation

□ **General and Thoracic Surgery**

□ **Hematology/Oncology**

Hepatology
- □ General liver
- □ Liver transplant

□ **Infectious Diseases**

Nephrology
- □ General nephrology
- □ Hypertension
- □ Kidney transplant

Neurology
- □ General neurology
- □ Headache
- □ Neurocutaneous
- □ Neuromuscular
- □ New onset seizures

□ **Neuropsychology**

□ **Neurosurgery**

□ **Otolaryngology**

□ **Physiatry**

□ **Plastic Surgery**

Pulmonology
- □ Pulmonology/asthma
- □ Synagis
- □ Technology dependent

Rheumatology
- □ General rheumatology
- □ Juvenile idiopathic arthritis (JIA)

□ **Sleep**

Specialty clinics
- □ 22q
- □ Aerodigestive
- □ Cerebral palsy
- □ Craniofacial
- □ Craniofacial feeding
- □ Craniofacial speech
- □ Cystic fibrosis
- □ Developmental progress
- □ Epilepsy/ketogenic diet
- □ Genetics/skeletal disorders
- □ Muscular dystrophy
- □ Neurofibromatosis
- □ Neurogastroenterology and motility
- □ Neuro spine
- □ Pain relief
- □ Pelvic and anorectal
- □ Physiatry
- □ Spasticity
- □ Spina bifida
- □ Strong4Life
- □ Technology dependent
- □ Tuberous sclerosis
- □ Vascular anomalies
- □ Other

If other, please specify: _____
_____

Indicate preferred provider and reason for preference, if applicable: _____
_____

Fax relevant clinic notes, patient demographics and imaging/diagnostic tests to 404-785-9111.

Was the patient's diagnostic testing (related to this referral) performed at Children's? □ Yes □ No

If yes, please do not fax these records.