

REFERRAL FOR SPECIALTY CONSULTATION Date: _____

Child's Name: _____ DOB: _____

Specialist referred to: _____

Date & Time of Appointment: _____

Clinical Problem:

Specific Questions I need answered:

Parent/Child Concerns:

Ongoing Care desired:

- _____ Consultation without ongoing subspecialty care
- _____ Phone discussion about specific shared roles in disease management
- _____ Chronic condition management locally between subspecialty visits
- _____ Subspecialty management of all aspects of the chronic condition with acute and primary care locally.

I would appreciate receiving a recent update or review article on:

Referring Doctor's Name: _____

Clinic Title: _____

Street Address: _____

Town, State, Zip: _____

Telephone/Fax/E-mail: _____

Easiest day/time to contact me: _____

Enclosed: _____ office/hospital progress notes
 _____ lab results
 _____ diagnostic studies/x-rays (_____ family will hand carry)