Yale Pediatrics A PRACTICE OF THE YALE MEDICAL GROUP

PEDIATRIC SPECIALTY NEW PATIENT FORM **Date:**_____

OPTION **If faxing a request, choose option 2 and fax form to number below. If calling to schedule an appointment (203-785-4081 #1), we will fax form to you for confirmation.**

1 □ **PHONE OPTION/APPOINTMENT CONFIRMATION:** Your patient has an appointment scheduled with _____ from the _____ service on _____ at _____ AM/PM. Please provide a brief medical history and current medications then fax this form to the appropriate number listed below **ALONG WITH PERTINENT MEDICAL RECORDS.**

□ **SELF REFERRED** □ **PROVIDER REFERRED**

2 □ **FAX OPTION/APPOINTMENT REFERRAL:** Please complete this form in its entirety and fax it to the appropriate number listed below **ALONG WITH PERTINENT MEDICAL RECORDS.**

Adoption	**203-737-7635**	Hematology/Oncology	203-737-2228	**Respiratory**	**203-737-7635**
Allergy/Immunology	**203-737-7635**	Hepatology	203-785-3365	**Rheumatology**	**203-737-7635**
Bone Clinic	**203-737-7635**	Infectious Diseases	203-785-6961	**Spina Bifida**	**203-737-7635**
Cardiology	**203-737-7635**	**MDA/Neuromuscular**	**203-737-7635**	**Thyroid Center**	**203-737-7635**
Develop. & Behavioral	**203-737-7635**	**Nephrology**	**203-737-7635**	Type 1 Diabetes	203-764-6748
Endocrinology	**203-737-7635**	**Neurology**	**203-737-7635**	**Type 2 Diabetes**	**203-737-7635**
GI	**203-737-7635**	**Obesity**	**203-737-7635**		

NOTE: SERVICES LISTED IN BOLD ARE INCLUDED IN THE ONE-CALL PROGRAM

Patient Name: _____ **DOB:** _____

Address: _____

Parent/Guardian Name(s): _____

Phone: (Day) _____ **(Evening)** _____ **(Cell)** _____

Primary Language if other than English: _____ **Interpreter Req:** □ **Yes** □ **No**

Insurance Company Name: _____ **ID #:** _____

Brief Medical History/Reason for Referral: _____

_____

_____

_____

Hospital Discharge: □ **Yes** □ **No** **If YES, Specialty Consulted In Hospital:** □ **Yes** □ **No**

Medications: _____

_____

Labs/Diagnostic Imaging/Records (Please indicate below records you are faxing with this form)

□ Bloodwork
□ Stool/Urine
□ Pertinent Office Records/Growth Charts
□ X-ray/other diagnostic imaging
□ Cardiac Tests
□ Neurologic Testing
□ Immunization Records
□ Other (specify): _____

PCP/Referring Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____ **E-mail(optional):** _____

For Yale Office Use Only

Appt. faxed back to PCP: Date: _____ Initials: _____ Info. sent to parent/guardian: Date: _____ Initials: _____

(To Be Completed For Fax Option Appointment Referrals Only)

Date Received: _____ Appointment Date:_____ Appointment Time: _____

Scheduled Provider: _____ Authorized By: _____

Parent/Guardian Notified: □**Yes** □**No:** Conversation:_____ Message: _____ Date: _____ Initials: _____

Final: 2/27/12

For additional copies, go to www.yalepediatrics.org or www.yalemedicalgroup.org/refer_a_patient

YALE NEW HAVEN CHILDREN'S HOSPITAL
YALE DEPARTMENT OF PEDIATRICS

PATIENT APPOINTMENTS ARE AS EASY AS 1-2-3

2 OPTIONS

1 Patient or referring office calls 203-785-4081 #1 to schedule appointment

2 Appointment scheduled immediately or within 24 hours if next available not acceptable

3 A pre-populated New Patient Form is faxed to referring office to complete and fax back with **pertinent medical records**

Adoption
Allergy/Immunology
Bone Clinic
Cardiology
Developmental/Behavioral Pediatrics
Endocrinology
GI
MDA/Neuromuscular
Nephrology
Neurology
Obesity
Respiratory Medicine
Rheumatology
Spina Bifida
Thyroid Center
Type 2 Diabetes

Demographic data and reason for referral necessary

1 Referring office faxes New Patient Form **completed in its entirety and pertinent medical records** to 203-737-7635

2 Appointment scheduled and patient notified within 72 hours

3 Appointment date/time forwarded to referring provider