

Specialty Request Form

Consult/Initiate Treatment Treatment Only Consult Only
(Consult = request for opinion/advise on diagnosing or treating)

Fax (309) 624-7778

- Adolescent Medicine
- Peds Gynecology
- Infectious Disease

Fax (309) 308-2009

- Allergy

Fax (309) 308-3935

- Cardiovascular Surgery
- Congenital Diaphragmatic Hernia
- Congenital Heart (Peoria)
- ENT
- General Surgery
- Orthopedics
- Spina Bifida
- Urology

Fax (815) 227-9242

- Congenital Heart (Rockford)

Fax (309) 624-5567

- Cystic Fibrosis

Fax (309) 655-4154

- Home Vent Clinic
- Pulmonology
- Sleep Medicine

Fax (309) 624-2481

- Diabetic Resource Center
(New Type 1 diagnosis call
309-624-2480)

Fax (309) 681-6965

- Developmental Pediatrics
- Psychiatry

Fax (309) 655-7392

- Eating Disorders

Fax (309) 624-9694

- Peds Resource Center

Fax (309) 624-9524

- Genetics

Fax (309) 623-4365

- Ophthalmology

Fax (309) 624-8884

- Endocrinology
- Gastroenterology
- Nephrology
- Neurology
- Obesity/Weight Mgmt.
- Palliative Care

Fax (309) 624-9733

- Neuropsychology
- Resource Link

Fax (309) 683-5855

- Neurosurgery

Fax (309) 655-6472

- Occupational Therapy
- Physical Therapy
- Speech Therapy

Fax (309) 624-9282

- Child & Adolescent Counseling

Fax (309) 624-9848

- St. Jude Clinic
Hematology/Oncology

Specialist Preferred/Requested: _____ **Time frame to be seen:** _____

Reason for Request (symptom(s) to be evaluated / condition(s) requesting feedback / treatment):

Patient Information:

First Name: _____ Last Name: _____ MI: _____

DOB: _____ Sex: M F Social Security Number: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Translator Needed: Yes No If yes, Language Needed: _____

Parent/Legal Guardian Information

Mother's Name: _____ Last Name: _____

Father's Name: _____ Last Name: _____

Other Relationship: _____ First Name: _____ Last Name: _____

Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Pager Phone: (_____) _____

Guarantor Information:

First Name: _____ Last Name: _____ MI: _____

DOB: _____ Sex: M F Social Security Number: _____

Requesting Provider: _____ NPI: _____

Collaborating Physician for Mid-Level Providers: _____

Office Contact Person: _____

Office Phone Number: (_____) _____ Office Fax Number: (_____) _____

Pre-Auth Required: Yes No Auth No.: _____ No. of visits authorized: _____

Please send the following information with referral:

- | | |
|--|---|
| <input type="checkbox"/> Patient Face Sheet | <input type="checkbox"/> All imaging related to condition(s)/symptom(s) |
| <input type="checkbox"/> Copy of insurance card/self-pay (legible, front & back) | <input type="checkbox"/> All lab results to condition(s)/symptom(s) |
| <input type="checkbox"/> Referral/Order generated by EMR | <input type="checkbox"/> List of current medication (including OTC & Herbals) |
| <input type="checkbox"/> Office visit notes pertinent to condition(s)/symptom(s) | <input type="checkbox"/> List of allergies |

Requesting Provider's Signature: _____

SPECIALIST OFFICE USE ONLY

Appointment Information: Appointment scheduled: Yes No Information sent to family: Yes No

Date: _____ Time: _____ Location: _____

Appointment with Dr.: _____