



New Appointment Request Form

Please attach all pertinent clinical and diagnostic information to this form and fax to **(206) 985-3333** # Pages: _____

Specialty referral guidelines for common diagnoses are available at www.seattlechildrens.org. Use of these guidelines will expedite the referral process and help ensure timely and appropriate consultation.

Click on the grey box to update the information for that field.

Note: You can also use **TAB** to move forward and **SHIFT+TAB** to move backward.

Patient's Name			Sex
Last:	First:	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female

Date of Birth:	Interpreter required? <input type="checkbox"/> Yes What language?	Medical Record #:
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Parent/Guardian's Name	Relationship

Address	City	State	Zip

Home Phone	Work Phone	Cell Phone
() -	() -	() -

Other Contact Information (e.g. emergency contact, email address)

	Insurance	Subscriber	Member/ID #	Group #
1				
2				

Note: An Insurance Referral Authorization may ALSO be required.
If so, the Insurance Processing Department at Children's will contact you to fax a separate form to (206) 985-3297.

SPECIALTY CLINIC/PROVIDER BEING REQUESTED: Gastroenterology, Dr. Christie - RAP STUDY CONSIDERATION (contact Melissa Young @ 987-1037).

Reason for Consultation
History of Present Illness/Chief Complaint: (include diagnosis & ICD-9 diagnosis code, if available)

Therapy/Tests and Results:

Clinic Notes/Additional information attached? Yes No

Who is requesting appointment? PCP Parent Other:

Second Opinion? Yes **Expected timeline to be seen?** **Contact name/#:**

Note: Appointments are prioritized by acuity and availability. The specialty clinic office will contact the patient's family regarding appointment scheduling within 2 business days from the receipt of this form. For questions, please contact the requested clinic.

Date:	Clinic Name (print):	Fax: () -
PCP Name (print):	PCP Signature:	Phone: () -
Referring Physician (if different than PCP):		Phone: () -

FOR CHILDREN'S USE ONLY

Appointment (Type): _____ **Date:** ___ / ___ / ___ **Time:** _____

Appointment (Type): _____ **Date:** ___ / ___ / ___ **Time:** _____

Scheduled in Pathways: _____ **Interpreter Ordered:** _____ **Information Mailed:** _____

Comments (use back of page if necessary):

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