UNIVERSITY of ROCHESTER MEDICAL CENTER

Name:
Date of Birth:
Insurance Plan:
ID #:
Guarantor:
Referral #:

MD Office Phone:
MD Office Fax:
MD Office E-mail: (optional):
Parent's Names:
Parent's Phone #:

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Referring Physician:
Reason for Referral:

Specific clinical question:

Level of Urgency: **Very _____ Moderate _____ Mild ____**

Brief History of Problem:

Related Hospitalizations:

Other specialties involved in care:

History of treatments tried for this problem (medications, PT, OT, dietary, etc.):

Current Medications *****If office uses an electronic medical record system, please print and fax past and current medication and problem lists:***

Allergies:

Pertinent PMH/PSH (*Please attach growth charts & applicable office notes)*:

Relevant vital signs and PE findings:

Pertinent labs or imaging— (*Please attach copies of any previous genetic testing results*):
For connective tissue referrals, Pediatric Genetics will send a questionnaire for the referring provider to complete. Pediatric Genetics does not evaluate, order testing, or provide counseling on MTHFR or pharmacogenetics. Patients that do not require a physical exam may be appropriate for a Genetic Counseling Only Visit.