GOLISANO CHILDREN'S HOSPITAL UNIFORM REFERRAL FORM

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 #:

****

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:

Allergies:

Pertinent PMH/PSH:

Relevant vital signs and PE findings:

Pertinent labs or imaging—(please attach copies of results):

- **Rheumatology please provide: CBC, diff., platelets, sed. rate, U/A, LFT's**
- **Obesity/metabolic syndrome: please provide fasting glucose, lipid profile and insulin level. Also HbA1c, free T4 and TSH.**

***Please attach growth chart.**
Please fax to appropriate division (#'s on back) and save original in patients chart.
(Electronic version of this form acceptable if sent as a fax).
Thank You.