

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	GI	203-737-7635	Neurology	203-737-7635
Allergy/Immunology	203-737-7635	Hematology/Oncology	203-737-2228	Respiratory	203-737-7635
Cardiology	203-737-7635	Hepatology	203-785-3365	Rheumatology	203-737-7635
Develop. & Behavioral	203-737-7635	Infectious Diseases	203-785-6961	Spina Bifida	203-737-7635
Diabetes	203-764-6748	MDA/Neuromuscular	203-737-7635	Thyroid Center	203-737-5972
Endocrinology/Obesity	203-764-9149	Nephrology	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)

- | | |
|---|---|
| <input type="checkbox"/> Bloodwork | <input type="checkbox"/> Cardiac Tests |
| <input type="checkbox"/> Stool/Urine | <input type="checkbox"/> Neurologic Testing |
| <input type="checkbox"/> Pertinent Office Records/Growth Charts | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> X-ray/other diagnostic imaging | <input type="checkbox"/> 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: _____

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
Cardiology
Developmental/Behavioral Pediatrics
GI
MDA/Neuromuscular
Nephrology
Neurology
Respiratory Medicine
Rheumatology
Spina Bifida

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