pediatrix | PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH

CLINIC REFERRAL FORM

	Today's Date:

PEDIATRIX PLASTIC AND RECONSTRUCTIVE SURGERY OF SAVANNAH
Fax: 912-335-3461 / Phone: 912-228-4605

Is this a joint case (to be coordinated with another surgical specialty)? ❑ Yes ❑ No
If yes, which specialty? _____

REASON FOR REFERRAL

Diagnosis/ ICD-9 Codes:

Name of Requested Clinician: *(If applicable)*	Onset Date of Signs and Symptoms: / /

Reason for Referral: ❑ Consultation and Recommendations, then return to referring provider for care ❑ Transfer of Care for this patient ❑ 2nd Opinion ❑ Helmet Fitting

Clinical Documentation: *(Required to expedite scheduling):*
Patient records and radiological reports have been: ❑ Faxed Date Sent:_____

REFERRAL SOURCE INFORMATION

Referring Provider Name:	Name of person filling out form:
Address:	Phone #:
	Fax #:

PATIENT INFORMATION

Last Name:	First Name:	Middle:

Parent/Guardian Name, if patient is under 18 years:

Interpreter Needed? ❑ Yes ❑ No If yes, language: ❑ Spanish ❑ Other_____

**For all patients new to Pediatrix, the following MUST be completed with a copy of demographic information.*
**For all patients already in the Pediatrix system, please update any changes below. If no changes, please go to Insurance section.*

Sex: ❑ M ❑ F	DOB: / /	SSN#:	
Street Address:	City:	State:	Zip Code:

Daytime Phone #:	Alternate Phone #:

INSURANCE INFORMATION
(Please attach a copy of the insurance information)

Insurance Name: *(note if no coverage)*	Authorization Required: ❑ Yes ❑ No Authorization #:_____ # of visits:___ Effective Dates:_____

CONFIRMATION OF SCHEDULED APPOINTMENT

(Once appointment has been scheduled by staff, the following information will be completed and faxed back)

Appt Date:_____ **Appt Time:**_____ **Provider Name:**_____