New Patient Referral/Consultation Information

Visit ____________________ Date: ______

Specialist: ______________________________

Specialty: ______________________________

Referring Clinician: ______________________

Name: ______________________________________

Address: ____________________________________

Birthdate/Age: __________________________ **Sex:** ______

Unit Number: ________________________________

Print clearly in ink or stamp with patient card.

Primary Care Clinician

Please complete top part and send to: ______________ at: ______ TODAY. Thank you!

Please ignore if you have already completed.

Reason for Referral: ______________________________________

Brief History *Including any work-up that has been done thus far*

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Special Concerns, if Any: ______________________________ ☐ Please Contact Me to Discuss

Current Meds: ______________________________________

Other Pertinent Information *Specialists seen, growth charts, lab results, etc. Please include pertinent copies with this form, if possible:*

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Specialist

Please complete and send to: ____________________________ at: __________ TODAY. Thank you!

Initial Diagnosis / Thoughts Behind It: *If applicable*

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Pertinent PE and Lab Findings So Far:

____

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Initial Plan:

I will:
- ☐ Obtain Labs/Other Procedures
- ☐ Prescribe Medications Perform
- ☐ Follow-up

Requests for Primary Care Clinician to:

- ☐ Obtain Studies: *Specify*

____

- ☐ See Patient for Follow-up Regarding:

____

- ☐ Please Contact Me to Discuss:

____

- ☐ Other:

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Full report to follow.

Developed by Christopher J. Stille MD, MPH, FAAP and colleagues at the University of Massachusetts