

**PEDIATRIC CONSULTATION CENTER**  
**BOX 100296, GAINESVILLE, FL 32610-0296**

**Pediatric Clinic/Service to which you are referring:**

**Today's Date:** \_\_\_\_\_

<b>GAINESVILLE:</b>	Allergy	Endocrinology	Gastroenterology	Genetics	Hematology/Oncology
	Immunology/Rheumatology	Infectious Disease	Nephrology	Neurology	Pulmonary
<b>LAKE CITY:</b>	Endocrinology	Hematology/Oncology	Neurology	Pulmonary	
<b>OCALA:</b>	Endocrinology	Hematology/Oncology	Neurology	Pulmonary	

**\*\*\*FOR SPECIALTIES/SERVICES NOT LISTED ABOVE, PLEASE CALL 352-265-0111\*\*\***

Physician Preference (if applicable): \_\_\_\_\_

Consultation *(Evaluation and recommendation to be used by referring physician for management of care w/ or w/o co-management by specialist.)*

Transfer of Care *(Evaluation and subsequent care management by specialist.)*

Current Diagnosis: \_\_\_\_\_

**Patient Information:**

Name (Last, First MI):	DOB:	Choose One: MALE FEMALE	SSN:
Mailing Address:	City:	State:	ZIP:
Guardian/Guarantor:	Relationship:		
Preferred Phone #:	Alternate Phone#:	IS INTERPRETER/TRANSLATOR NEEDED? If yes, what language?	YES NO

**Insurance Information:**

Insurance Company:	Policy #:	Group #:
Subscriber Name (Last, First MI):	DOB:	Choose One: MALE FEMALE
Employer:	*Authorization #:	
Ins Phone #:	Auth Exp. Date:	

\*Please include authorizations for: Capital Health (CHP), Cigna (must have Rx), CMS Title XXI out of district (must have name), Coventry, First Coast Advantage, First Health, FL Health Care (Healthy Kids), Healthease/Staywell/Wellcare, Medipass, Prestige, Ped-I-Care, Tricare Prime.  
*Medicaid HMOs may not be accepted.*

**Referring Physician Information:**

Name (Last, First MI):	Contact:
Mailing Address:	City: State: ZIP:
Phone #:	Fax #: Medipass Provider: YES NO

**PLEASE REFER TO PAGE 2 FOR A LIST OF DOCUMENTS/INFORMATION TO INCLUDE WITH REFERRAL**

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With this referral, please include the following items per the clinic/service to which you are referring. Please check to indicate that item is attached. Please write "N/A" if item is not available.

If a second opinion is being sought, the previous specialist's dictation and work-up must be included.

**ALLERGY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports

**GASTROENTEROLOGY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports  
 History & Physical  
 Growth Charts

**HEMATOLOGY/ONCOLOGY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports

**INFECTIOUS DISEASE**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports  
 Immunization Records

For recurrent fevers or fevers of unknown origin:

CBC w/diff/platelet  
 CMP  
 ESR  
 CRP  
 EBV IgG/M  
 CMV IgG/M  
 ANA  
 RF  
 HIV  
 Urinalysis w/ culture  
 Blood culture w/ fevers  
 PPD

**PULMONARY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports

**ENDOCRINOLOGY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports  
 Growth Charts  
 Bone Age Studies  
 Lipid Panel  
 Glucose, Insulin Levels

**GENETICS**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports

**IMMUNOLOGY/RHEUMATOLOGY**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports  
 Immunization Records

**NEPHROLOGY/RENAL**

Clinic Notes  
 Lab Work  
 Diagnostic Radiology Reports  
 Urinalysis  
 Renal U/S

**NEUROLOGY**

Office/Clinic Notes (last 2 visits)  
 Lab Work (last 12 months)  
 Brain/Imaging Reports (Films/CDs may be requested prior to appt at Neurologist's discretion)  
 EEG, EMG, EP, PSG Reports  
 ED/Hospital Discharge Summaries