

# Valleywise Health

2601 E. ROOSEVELT • PHOENIX, ARIZONA 85008

## PEDIATRICS SPECIALTY REFERRAL



DT345

Patient Identifier

**Place Patient Label Here**

**Fax to: 602-655-9142**     Routine     Urgent

Date of referral:	Practice Name:
Referring Provider:	PCP <input type="checkbox"/> same as referring
Referring Provider Signature:	
Practice Referral Contact Person:	
Practice Contact Phone#:	Practice Contact Fax#:

**Patient Demographic Information**

Patient Name:	DOB:
Parent/Guardian Name:	Relationship:
Parent/Guardian Phone#:	Alternate Phone#: <input type="checkbox"/> none
Patient Address:	
Patient's Insurance	Insurance ID#:
	Group:
Authorization Number:	#Visits: <input type="checkbox"/> Requested but pending <input type="checkbox"/> No Auth. required

**Service Type Requested**

Pediatric Medical Specialty Requested:			Outpatient Procedure
<input type="checkbox"/> Adolescent	<input type="checkbox"/> Gastroenterology *	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> Audiology	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> EKG (Walk-in M-F 7:00am-3:00pm)
<input type="checkbox"/> Burn Clinic (Call 602-344-5112)	<input type="checkbox"/> Neurology	<input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT	<input type="checkbox"/> Holter Monitoring
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Surgery	<input type="checkbox"/> Medical Imaging (Call 602-344-1300 or fax 602-344-1313) (Please also complete Medical Imaging Referral form in its entirety to expedite scheduling)
<input type="checkbox"/> Dental	<input type="checkbox"/> OB/GYN (Teen OB)	<input type="checkbox"/> Travel Clinic	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Ortho (Trauma only)	<input type="checkbox"/> Urology *	
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Optometry/Ophthalmology	(No eye exams/Medical only ages 4+)	
<input type="checkbox"/> ENT	<input type="checkbox"/> Other		

**\*Closed to new patients for now**                      **Clinical Information:**

Reason for referral:

Diagnosis:                      Dx Code:

In order to assist us in providing the best care for your patient, please include copies of the following critical clinical information as well as results of any diagnostic testing that may have already been done and let us know what is pending.

Recent Progress notes:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Problem List:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Medication List:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Immunizations record:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Growth Chart:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Relevant X-ray reports: (Recent CXR needed for Cardiology)	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	<input type="checkbox"/> Pending
Notes from previous specialists if not AzCC	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Recent Pertinent Lab results	<input type="checkbox"/> Attached	<input type="checkbox"/> None available	<input type="checkbox"/> Pending
Other pertinent diagnostic reports (i.e. EEG, EKG)	<input type="checkbox"/> Attached	<input type="checkbox"/> None available	<input type="checkbox"/> Pending

Valleywise Comprehensive Healthcare Center  
2525 E Roosevelt Street Phoenix AZ, 85008

**Pediatric Scheduling #: 602-344-5887; Pediatric Clinic #: 602-344-1018 Fax # for Referrals: 602-655-9142**

or Email: [Perla.Zamarron@Valleywisehealth.org](mailto:Perla.Zamarron@Valleywisehealth.org)