Nemours® Children's Hospital

Appointment Request Fax

TO: **Nemours Children's Hospital**

FAX NUMBER: **(407) 650-7124**

PHONE NUMBER: (407) 650-7715

DATE:

FROM: ______________________________

FAX NUMBER: ______________________________

PHONE NUMBER: ______________________________

TOTAL NUMBER OF PAGES INCLUDING COVER: ______________

REFERRING PHYSICIAN INFORMATION:

Referring Physician Name: ______________________________

Physician Phone: ______________________________ Fax: ______________________________

Reason for Visit (Diagnosis/Symptoms): ______________________________

Specialty Requested (and Provider, if Preference): ______________________________

Please indicate if this request is for:

- ❑ A consultation (opinion or advice)
- ❑ Transfer of care for a specific problem
- ❑ Other ______________________________

PLEASE FAX ALL PERTINENT MEDICAL RECORDS INCLUDING X-RAYS, LABS AND TEST RESULTS TO (407) 650-7124.

PATIENT INFORMATION:

Patient's Name: ______________________________ DOB: ______________

Parent's or Legal Guardian's Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Daytime Phone: ______________________________ Secondary Phone Number: ______________________________

Insurance Name: ______________________________ Policy Holder Name: ______________________________

ID or Policy Number: ______________________ Group Number: ______________ # of Visits: ______________

Authorization Number ______________________ Effective Date: ______________ Expiration Date: ______________

*****Upon receipt of the above information, we will contact the parent/guardian to make an appointment.*****

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This portion to be filled out by Nemours Staff: Once appointment is scheduled, Nemours will confirm with referring physician.

Appointment Date: ______________ Appointment Time: ______________ Physician: ______________________________

( ) Patient contacted ( ) Couldn't contact patient, PCP please follow up with patient Medical records received (Y) (N)

Comments: ______________________________

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