General Referral Form

children's health®

Date

Preferred Location ☐ Dallas ☐ Plano Other

Preferred Physician

Clinic/Specialty Being Referred To

Reason for Appointment (Please Specify the Necessity/Primary Problem)

Patient Information

Patient's Name (LAST) (FIRST) ☐ Male ☐ Female

Patient's Date of Birth / / Primary Language Spoken

Patient's Phone Number

Referring Physician Information

Primary Care Provider (PCP)

Referring Provider Name (if different from above)

Referring Provider signature (or designee)

Referral Coordinator Name

Referral Coordinator Direct Phone Line

Referral Coordinator Fax Number

Please include the following information, if available as it pertains to this referral

- PATIENT DEMOGRAPHICS FORM/PROVIDER REFERRAL FORM (if available)
- COPY OF INSURANCE CARD/INFORMATION
- VISIT NOTES (pertinent to the referral)
- RECENT LABORATORY STUDIES
- X-RAY/RADIOLOGY REPORTS (we may ask for studies to be brought on CD)
- GROWTH CHART

PHRE_170803

Referrals will be processed as they are received. Due to high demand in some clinics, appointment requests may be prioritized based on urgency/need. Clinics may ask for further information on specific referrals and will contact your referral coordinator. If a referral is considered urgent, please contact the clinic or Provider Services to facilitate a phone consult. Thank you for referring your patient to Children's Health.

Call Provider Services | 214-456-9933 **For fax numbers, please visit childrens.com/refer**