FAX REFERRAL APPOINTMENT REQUEST

Boston Children's Hospital
Until every child is well™

FAX TO BOSTON CHILDREN'S PRACTICE LIAISON PROGRAM: **617-919-3033**
If you have questions or require assistance, call **844-BCH-PEDS** (844-224-7337), Mon. – Fri., 7 a.m. – 8 p.m. EST

Date: _____

PATIENT

Patient: _____

DOB: _____

Parent/Legal guardian: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone (check preferred): ❑ Home _____

❑ Work _____ ❑ Mobile _____

Email: _____

Language: ❑ English ❑ Spanish Other _____

INSURANCE

We will call the family to confirm this information.

Insurer: _____

Plan name: _____

NOTE: If out-of-state Medicaid, prior authorization and a single-case agreement will likely be required.

APPOINTMENT INFORMATION

Boston Children's will make every effort to promptly schedule appointments and second opinions. In some cases, additional medical history may be required prior to scheduling.

For urgent appointments or clinical consults, call the Center or Service directly. If you need help connecting to the correct specialty, call **844-BCH-PEDS**.

Do not use this form for direct admissions or hospital transfers.
Call the Coordinator of Patient Placement (COPP) at **617-355-0000**.

IN CASE OF EMERGENCY, DIAL 9-1-1.

PRIMARY CARE PHYSICIAN

Name: _____

Practice/Facility: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

If a Boston Children's clinician has follow-up questions, contact:

Direct phone: _____ Email: _____

REFERRING PHYSICIAN (if different from PCP)

Name: _____

Practice/Facility: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

If a Boston Children's clinician has follow-up questions, contact:

Direct phone: _____ Email: _____

KEY INFORMATION

Is this a second opinion? ❑ Yes ❑ No

Reason for referral or chief complaint: _____

_____

_____

Requested Boston Children's physician(s): _____

_____

Specialty(ies): _____

Primary diagnosis: _____