

Clinician Reason for Visit

Please use this tool to communicate the reason for visit along with any clinically relevant information that the BCH subspecialist should know in anticipation of your patient's visit.

Referring Provider:	Today's Date:
Patient Name: DOB: Phone Number(s):	Patient Address:
Requested Subspecialty:	Requested Referral Relationship: <input type="checkbox"/> One-time consultation <input type="checkbox"/> Co-management/shared care <input type="checkbox"/> Subspecialty-based management <input type="checkbox"/> To be determined
Clinician Reason for Visit:	Relevant Clinical/ Psychosocial Information:
Recommended Timeframe of Appointment: <input type="checkbox"/> 24-48 hrs (Urgent) <input type="checkbox"/> 72hrs-1 week <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 4-6 weeks <input type="checkbox"/> No preference	Clinical Documentation Included: <input type="checkbox"/> Recent progress note <input type="checkbox"/> Recent well child visit <input type="checkbox"/> Lab results <input type="checkbox"/> Imaging studies <input type="checkbox"/> Growth chart <input type="checkbox"/> Other:
Referring Physician Practice Information:	Additional Information: