

Children's Hospital QUICKFAX Request for Service & Physician Order Form

DATE: _____

Fax form to **FAX# (804) 228-5857** Call Patient Services at (804) 228-5818 or (800) 443-0893 for assistance.

REFERRING PHYSICIAN INFO

Name: _____ Phone # _____ Fax # _____

PATIENT INFO

Note: A data/registration sheet from physician's office may be included in lieu of patient information requested below.

Name _____

Date of Birth _____ Patient Social Security # _____

Parent/Guardian Name _____

Address _____

Phone#s Home/Cell _____ Mom's Work _____ Pls. verify with family.

Dad's Work _____ Other Contact _____

Reason for Referral _____

Diagnosis _____ ICD-9 code _____

PATIENT INSURANCE INFO

Insurance Co Name _____

Name of Policy Holder _____

Place of Employment _____

Insurance ID# _____

Group # _____

Insurance Co Phone _____

Insurance Co Address _____

THERAPY SERVICE(S) ORDERED

Services available at West & South are OT, PT, Speech & Psychology. Services available in Fredericksburg are OT, PT and Speech.

___ Nutrition ___ Occupational Therapy ___ Physical Therapy

___ Psychology/Neuropsychology ___ Speech/Language Pathology

___ Infant Services Developmental Evaluation (under 3)

Assistive Technology Evaluations:

Equipment Evaluations:

___ Smart Suite

___ Computer/Computer Access ___ Bath Equipment ___ Walker/Stander

___ Augmentative Communication ___ Environmental Control ___ Wheelchair

THERAPY ORDER INSTRUCTIONS

___ Evaluation Only ___ Limitations _____

___ Evaluation & Treatment ___ Duration _____

INSURANCE REFERRAL INFORMATION

Please submit a separate referral for each service requested. Please indicate how your office plans to handle this part of the referral process.

___ Insurance referral/authorization: _____

Begin Date: _____ End Date: _____ Number of visits: _____

___ Referral number not required by insurer

___ Appointment required by insurer prior to providing referral.

___ Referral form faxed to Children's Hospital fax # 228-5857 on _____ (date)

___ Referral form given to parent to take to Children's Hospital.

PHYSICIAN SPECIALTY SERVICE REQUESTED

___ Dental ___ Multispecialty Clinics

___ Children's Feeding Program Cerebral Palsy

Need a referral for each: Muscular Dystrophy

Physician Spasticity

Psychologist Spina Bifida

Nutritionist ___ PM&R

Other _____

OTHER DIAGNOSTIC SERVICE REQUESTED

___ Motion Analysis Lab for: _____

___ Radiology for: _____

FOR INTERNAL USE ONLY

Physician Informed _____

Appointment Scheduled: Date: _____ Time: _____

Patient's family declines services _____

Unable to reach patient's family _____

Copy sent to Medical Records _____

Other _____

CH MEDICAL RECORD# _____

PHYSICIAN/HEALTH CARE PROVIDER :

SIGNATURE _____ DATE _____

Children's Hospital
PEDIATRIC SPECIALTY CARE OF RICHMOND, VA