Check One ➡

Pediatric Specialty	Fax Number	Pediatric Specialty	Fax Number
☐Cardiology	864-241-9202	☐Neurology	864-241-9206
☐Dev/Behavioral/Psych	864-241-9205	☐Neurosurgery	864-797-7469
☐Endocrinology	864-241-9238	☐New Impact	864-627-9131
☐Gastroenterology	864-241-9201	☐Pulmonology	864-241-9246
☐Hematology/Oncology	864-455-5182	☐Rheumatology	864-241-9202
☐Infectious Disease	864-241-9202	☐Sleep Medicine	864-241-9233
☐ Ophthalmology	864-241-9276	☐Surgery	864- 241-9255
☐Nephrology	864-241-9200	☐Urology	864-241-9200

Date of Consultation Request: ______________________________

If the patient is not in the custody of the biological parent, please fax custody papers with this referral. Thank you.

Patient Name: ____ DOB: __________ Sex: M F

Street Address: ____ Apt/Suite: ________

City/State: ____ Zip: ______________________

Parents Name(s): ____

Home Phone: _________________ Work Phone: _________________ Cell Phone: ____________

English Speaking? ☐ YES ☐ NO If no, preferred language: ______________________________

Physician requesting consultation: ______________________________Phone: ______________
(Doctor or Nurse Practitioner, not practice)

Name of Person Completing this form: ____________________________Fax: ___________________

Diagnosis: ____

1. Has the patient been previously evaluated for these concerns? ☐ YES ☐ NO
   If yes, by whom and when? _________________________________***Please include these records if available

2. Does the patient have a sibling who is followed by us? ☐ YES ☐ NO
   If yes, provide Name and date of birth ____

3. ***Cardiology only:*** ECW Notes – Please list encounter date to reference ____________________

4. ***Developmental/Behavioral/Psych only:*** What primary question would you like addressed?
   ____

5. ***Neurology only*** *(please check):* ☐ Consult only ☐ EEG Only ☐ Consult & EEG

6. ***Pulmonology only*** *(please check):* ☐ Consult only ☐ PFTs Only
   Consult with: Dr.______________________ (if not specified first available appointment will be filled)
   * New patients MUST bring their radiologic studies to the appointment on a CD or DVD.

The consult process will be expedited if we receive ALL of the following:

- Insurance Type ____________________________ please include a copy of card and face sheet if available.
  - **FOR ALL Specialties a PRIOR AUTH is required for: Tricare Prime; Tricare Remote and HMO Blue Choice Health Plan of SC and State beginning with ZCC**
- For non-GHS referring physicians, please include your demographic sheet.
- Last 2 OV notes and other notes pertinent to the diagnosis
- Results X-Ray, Lab Reports, Growth Charts, and other Related Studies to diagnosis

*** If this is a second opinion, we will need the notes, labs, tests from the initial opinion**.

To be completed by Specialty Office and returned via fax to Referring Physician as appointment confirmation *updated March 2014*

The patient's evaluation has been scheduled for ____________________________________

In our ______________________ office with Dr. ____

A referral packet has been mailed to the family and we have also:

______Spoke with the parent/guardian

______Message on machine

______No answer-no machine; #disconnected; wrong # or fast busy

Thank you for your referral