University Pediatrics
New Patient Referral/Consult Fax Form

Today's Date: _____ Person making referral: _____

Referring Provider: _____Referring Practice:_____

Provider Address: _____

Provider Phone: _____ Provider Fax: _____

Patient Name: _____ Male / Female

Date of Birth: _____ SS#: _____

Language Spoken: _____ Race: _____ Ethnicity: _____

Reason for referral: _____

❒ 24 hours (requires physician to physician phone call) ❒ 1 Week ❒❒ First Available ❒ Other

Check all that apply: (Give specific details below)
❒ Consultation ❒ Outpatient Procedure

❒Cardiology	❒Nephrology	❒Neurology	❒Pulmonology
❒Echocardiogram	❒Ultrasound	❒EEG	❒PFTs
❒EKG			

_____

_____

Guardian/Guarantor name: _____ Date of Birth:_____

Home phone: _____Work phone:_____Cell phone:_____

Address: _____

City:_____ State: _____ Zip Code: _____

Primary Insurance: _____ ID#: _____

Insured name:_____ Date of Birth:_____

Insurance Referral/Authorization # _____

Please attach a copy of the primary and secondary (if applicable) insurance card.

***Please fax all pertinent lab and clinical data with this cover sheet to the appropriate office.**

❒ Child Development & Behavioral Health
8301 Farrow Road
Fax: (803) 935-5206
❒ Pediatric Cardiology, 9 Medical Park, Suite 110
Fax: (803) 434-2262
❒ Pediatric Endocrinology, 9 Medical Park, Suite 230
Fax: (803) 434-4669
❒ Pediatric Hematology/Oncology, 7 Medical Park, Suite7215
Fax: (803) 434-3094
❒ Pediatric Infectious Disease, 9 Medical Park, Suite 210
Fax: (803) 434-7983
❒ Pediatric Nephrology, 9 Medical Park, Suite 270
Fax: (803) 434-8607
❒ Pediatric Neurology, 9 Medical Park, Suite 110
Fax: (803) 434-7981
❒ Pediatric Pulmonology, 9 Medical Park, Suite 505
Fax: (803) 434-2181

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