Mary Bridge Referral Cover Sheet

Mary Bridge Children's Hospital • Clinics • Foundation

FAX REFERRAL TO
(253) 864 – 3939

❑ Urgent

PATIENT INFORMATION

Patient Name:_____ **D.O.B** ____/____/_____

Parent/Guardian: _____ **Phone:** (____)_____ - _____

Address: _____ **Insurance:** _____

Subscriber:_____ **Guarantor**:_____

(please indicate if the child is in **Foster Care – if so, include caregiver authorization form)**

REFERRAL REQUEST INFORMATION

Referring Provider:_____

Contact person and **phone number** for referring office:_____ (_____)_____ - _____

Primary Care Provider (if different from referring) _____

Specialty or **Therapy Department for referral at Mary Bridge:**_____

Reason for referral: _____ **Diagnosis Code**: _____

_____

** Provide current chart notes and current lab results related to the Dx

For the following **Specialties, please also include**:

Audiology ❑ Referral required	**Endocrine** ❑ Growth Charts ❑ Labs	**ENT** ❑ Current audiology report or hearing exam results	**Genetics** ❑ Growth Charts ❑ Imaging studies
Neonatal Follow Up ❑ Referral required	**Neurobehavioral and Psychiatry** ❑ Recent Evaluations	**Neurology** ❑ All imaging related to referral ❑ Growth chart if under 5 years old / head circumference	**Nutrition** ❑ Referral required
OT ❑ Referral required	**Orthotics** ❑ Referral required	**Orthopedics** ❑ Date of Injury___/___/_____ ❑ Is it a MVA? ❑ Current images / or where images were taken? ❑ PT or other notes	**Physical Medicine and Rehab** ❑ Referral required
PT ❑ Referral required	**Speech Therapy** ❑ Referral required		

Once we receive your referral, we will attempt to make contact with your patient to schedule the appointment. We will advise you if we have been successful in scheduling your patient.

Thank you for your referral.