Mary Bridge Referral Cover Sheet

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**: _____

_____

** <u>Provide current chart notes and current lab results related to the Dx</u>

For the following **Specialties, <u>please also include</u>**:

Audiology ❑ Referral required	**Endocrine** ❑ Growth Charts ❑ Labs	**ENT** ❑ Current audiology report or hearing exam results	**Genetics (referral required)** ❑ Growth Charts & Head Circ. ❑ Imaging studies ❑ Previous Genetic Testing ❑ Signs & Symptoms for Referral
Neonatal Follow Up ❑ Referral required	**Neurobehavioral Medicine** ❑ Developmental Behavioral ❑ Neuropsychology ❑ Psychiatry ❑ Psychology	**Neurology** ❑ All imaging related to referral ❑ Growth chart if under 5 years old / head circumference	**Nutrition** ❑ Referral required
OT ❑ Referral required ❑ Assistive Technology	**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	**Rheumatology** ❑ Chart notes related to referral ❑ Imaging related to referral ❑ Labs related to referral	**Speech Therapy** ❑ Referral required	

Once we receive your referral, we will attempt to make contact with your patient to schedule the appointment.

Thank you for your referral.