



# Request for a Specialty Clinic Appointment

*For Specialty Office Use:*

Date Received: \_\_\_\_\_

Date, Time of Appt.: \_\_\_\_\_

Location of Appt.: \_\_\_\_\_

Specialty or MD: \_\_\_\_\_

Specialty Phone #: \_\_\_\_\_

Specialty Fax #: \_\_\_\_\_

## PATIENT DEMOGRAPHICS - Demographic sheet may be attached.

Patient's Last Name:	Patient's First Name:	Middle Initial:	Preferred name to go by:
DOB:	Age:	Sex:	Race:
Street Address:		Home Phone #: (     )	
City:		Work Phone #: (     )	
State:	Zip Code:	Cell Phone #: (     )	
Parent/Guardian's Name:			

## INSURANCE INFORMATION - If patient has Medicaid, please also fax/send Medicaid Referral Form.

Person Responsible for Bill:	Relationship to Patient:	
Primary Insurance Company:		
Primary Policy #:	Group #:	
Card Holder's Name:	DOB:	Address (if different than above):
Secondary Insurance Company (if applicable):		
Secondary Policy #:	Group #:	
Card Holder's Name:	DOB:	Address (if different than above):

## DIAGNOSIS

Diagnosis/Reason for Referral/Other Health Problems:	
Date of Injury:	MV or Other:

## REFERRING PHYSICIAN INFORMATION

Name:	Doctor's UPIN#:	Individual NPI#:
Phone #:	Fax #:	PCP (if different from above):
Referral #:	Contact Person:	

## ADDITIONAL INFORMATION

Interpreter Needed:	YES	Language/Hearing/Other Requested:	
Allergies:	YES	NO	If yes, please list:

## CURRENT MEDICATIONS / HERBAL PRODUCTS / NUTRITIONAL SUPPLEMENTS

*Medication Reconciliation Form or copy of assessment in chart may be attached.*

Name:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. Complete and fax front side of this form to Specialty Fax # listed below.
2. See “Guide to the Scheduling Appointments” for any further records requested by the Specialty. Please fax these documents at the same time you fax this form. This helps keep records and forms together, eliminates duplication of tests performed on the patient and improves the overall care each child receives at Children’s. Thank you.
3. If insurance requires a referral (Medicaid, etc.), please fax referral with this form as well.

Specialty	Fax #	Guide to Scheduling Appointments	Phone #
<b>Adolescent Medical Autism Clinic</b>	(205) 558-2071 (205) 975-6503	Fax insurance referral, all relevant records, completed MAC Intake (ASD with co-morbidities)	(205) 939-9141 (205) 939-5275 or (205) 939-5277
<b>Allergy/Immunology</b>	(205) 939-6096	Fax all relevant* records, labs and immunization records to (205) 212-2724.	(205) 939-9141
<b>Cardiology</b>	(205) 975-6291	Fax all relevant* records, labs, EKGs and imaging tests with ATTN: Lisa. All appointments are in Suite 9100 of the new UAB Women and Infant Center.	(205) 934-3460
<b>Children’s Behavioral Health</b>	(205) 939-9949	All appointments are made by phone and are scheduled by patient’s legal guardian.	(205) 939-9193
<b>Dental</b>	(205) 939-9796		(205) 939-9141
<b>Dermatology</b>	(205) 939-6096	Fax all relevant* records and labs to (205) 824-4994.	(205) 939-9141
<b>Endocrinology/ Diabetes</b>	(205) 934-5544 (205) 939-9821	Fax growth charts, all relevant* records, labs, current demographic information.	(205) 939-9107 Option 2
<b>Down Syndrome Clinic</b>	(205) 212-2994	Send most recent clinic notes, labs, growth chart.	(205) 939-9585
<b>ENT (Pediatric ENT Associates)</b>	(205) 824-4983 (205) 824-4982	Fax all relevant* records, labs and imaging prior to appointment marked ATTN: Appointment date and time	(205) 824-4949 Option 2
<b>Gastroenterology</b>	(205) 939-9152	Fax all relevant* records, labs and imaging	(205) 939-9918
<b>Hematology/Oncology</b>	(205) 975-1941	Fax all relevant* records, labs and imaging; ATTN: Kandi Barnett	(205) 939-9285
<b>Infectious Disease</b>	(205) 975-6549	Fax all relevant* records and labs.	(205) 934-2441
<b>Nephrology</b>	(205) 975-7051	Fax all relevant* records, labs, ultrasounds, VCUGs. Send all study films to the appointment with patient.	(205) 939-5818 or (205) 939-9781
<b>Neurology</b>	(205) 212-2008	Fax all relevant* records, labs, MRIs, CTs and EEGs. Send relevant** imaging to the appointment with patient.	(205) 996-7850
<b>Neurology (Chil. South)</b>	(205) 824-5879	Fax all relevant* records, labs, MRIs, CTs and EEGs. Send relevant** imaging to the appointment with patient.	(205) 824-5881 or (205) 824-5880
<b>Neurosurgery</b>	(205) 939-9972	Fax all relevant* records and infant head growth chart (if applicable). Send relevant* imaging to appt. with patient.	(205) 939-9653
<b>Orthopedics</b>	(205) 939-6049	Send x-ray, CT, MRI films with patient to appointment.	(205) 939-9146 Option 1
<b>Plastic Surgery</b>	(205) 939-5340	Appt. email address: <a href="mailto:plastic.appointments@chsys.org">plastic.appointments@chsys.org</a> Send x-ray, CT, MRI films with patient to appointment.	(205) 939-9369
<b>Pulmonary Medicine</b>	(205) 975-5983	Fax insurance referrals to (205) 212-2018.	(205) 939-9583 Option 1
<b>Rehab Medicine</b>	(205) 939-9793	Fax clinic note from referral to source to (205) 939-9793.	(205) 939-9141
<b>Rheumatology</b>	(205) 212-2734	Fax all relevant* lab, imaging results and records to (205) 212-2734. Please include appt. date and time.	(205) 939-9438
<b>Sports Medicine</b>	(205) 975-6109	Send x-ray films to the appt. with the patient.	(205) 934-1041
<b>Surgery, General</b>	(205) 975-4972	Fax all relevant* records, labs. MRIs and CTs.	(205) 939-9688
<b>Urology</b>	(205) 975-6024	Fax all relevant* records and labs. Send x-ray, CT, MRI films with patient to appointment.	(205) 939-9840
<b>Weight Management</b>	(205) 212-2735	Fax all relevant* records (insurance referral - if needed, lab work - within last 6 months), growth chart and clinic notes. Please indicate if patient is being referred for LESTER® (ages 6-11), Healthier Weigh® (ages 12-18) or bariatric surgery.	(205) 939-5278

\* Relevant: All documentation related to the specific diagnosis for which the patient is being referred.  
 CHS Centralized Scheduling (ACCESS) Phone: (205) 939-9141 or (800) 226-4770.