

REQUEST FOR A SPECIALTY CLINIC APPOINTMENT



Children's
of Alabama®

Specialty
Specialty MD _____
Specialty Phone _____
Specialty FAX _____

For Specialty Office Use
Date Received _____
Appointment Date/Time _____
Appointment Location _____

PATIENT DEMOGRAPHICS

Demographic sheet may be attached.

PATIENT NAME _____
Last First Middle Initial Preferred Name to go by
DOB _____ AGE _____ SEX _____ RACE _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____
Street City State Zip
PHONE _____
Check preferred Home Work Cell
Contact Number
PARENT/GUARDIAN _____ DOB _____ EMAIL _____

INSURANCE INFORMATION *If patient has Medicaid, please also fax/send Medicaid Referral Form (EPSDT Screening).*

PERSON RESPONSIBLE FOR BILL/GUARANTOR _____ RELATIONSHIP TO PATIENT _____ DOB _____
PRIMARY INSURANCE COMPANY _____
PRIMARY POLICY NUMBER _____ GROUP NUMBER _____
CARD HOLDER'S NAME _____ DOB _____ ADDRESS (if different from above) _____
SECONDARY INSURANCE COMPANY (if applicable) _____
SECONDARY POLICY NUMBER _____ GROUP NUMBER _____
CARD HOLDER'S NAME _____ DOB _____ ADDRESS (if different from above) _____

DIAGNOSIS

DIAGNOSIS/REASON FOR REFERRAL/OTHER HEALTH PROBLEMS _____
DATE OF INJURY _____ MV OR OTHER _____

REFERRING PHYSICIAN INFORMATION

NAME _____ INDIVIDUAL NPI NUMBER _____
PHONE NUMBER _____ FAX NUMBER _____ PCP (if different from above) _____
REFERRAL NUMBER _____ CONTACT PERSON/EXTENSION _____

ADDITIONAL INFORMATION

INTERPRETER NEEDED? YES NO 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

SPECIALTY	FAX	HOW TO SCHEDULE APPOINTMENT	PHONE
Medical Autism Clinic	205.638.2526	Fax insurance referral, all relevant* records, completed MAC Intake (ASD with co-morbidities). New patients ages 2-8 only.	205.638.5277
Adolescent Health Center	205.638.2071	By physician referral only.	205.638.9141
Allergy/Immunology	205.638.2833	Fax all relevant* records, labs and immunization records.	205.638.6993
Cardiology	205.975.6291	Please call the office to schedule an appointment. After the appointment is scheduled, information will be provided regarding records, labs imaging, etc., to be faxed.	205.934.3460
Children's Behavioral Health	205.638.9949	All appointments are made by phone and are scheduled by patient's legal guardian. Legal guardian must call for an appointment.	205.638.9193
Dental	205.638.9796		205.638.9161 or 205.638.9141
Dermatology	205.638.2851	Fax all relevant* records and labs to 205.638.2851.	NEW PT 205.638.5759 FOL/UP 205.638.9141
Developmental Medicine	205.638.2526	Relevant records will be discussed once appointment is made.	205.638.2294
Endocrinology/Diabetes	205.638.9821	Fax growth charts, all relevant* records, labs, current demographic information.	205.638.9107 Option 2
ENT (Pediatric ENT Associates)	205.638.4983	Fax all relevant* records, labs and imaging prior to appointment marked ATTN: Appointment date and time.	205.638.4949 Option 2
Gastroenterology	205.638.9919	Fax all relevant* records, labs and imaging.	NEW PT 205.638.5457 FOL/UP 205.638.9141
Hematology/Oncology	205.975.1941	Fax all relevant* records, labs and imaging; ATTN: Lisa Allred	205.638.9285
Infectious Disease	205.975.6549	Fax all relevant* records, labs, growth chart, immunization records and demographic information.	205.934.2441
Intensive Feeding Program	205.638.7995	Fax all relevant* records, growth charts. Complete Supplemental Referral Sheet at www.childrensal.org/patient-referral	205.638.7590
Nephrology	205.975.7051	Fax all relevant* records, labs, ultrasounds, VCUGs. Send all study films to the appointment with patient.	205.638.9781
Neurology	205.212.2008	Fax all relevant* records, labs, MRIs, CTs and EEGs. Send relevant* imaging to the appointment with patient.	205.996.7850
Neurology (Children's South)	205.638.5879	Fax all relevant* records, labs, MRIs, CTs and EEGs. Send relevant* imaging to the appointment with patient.	205.638.5881 or 205.638.5880
Neurosurgery	205.638.9972	Fax this form completed, insurance referral, clinical note, imaging reports, ALL growth charts (3 and under). Parents MUST bring outside imaging CD to appointment.	205.638.9653
Oral Maxillofacial Surgery	205.987.5034	Fax all relevant records; email all x-rays to kmmcbride@uabmc.edu	205.987.1173
Orthopedics	205.638.3699	Send x-ray, CT, MRI films with patient to appointment.	205.638.3373
Plastic Surgery	205.638.5340	Appointment email address: plastic.appointments@ChildrensAL.org Send x-ray, CT, MRI films with patient to appointment.	205.638.9369
Pulmonary Medicine	205.638.2850	Fax this form with correct patient insurance information and referral to ATTN: Pulmonary Scheduler.	205.638.9583 Option 1
Rehab Medicine	205.638.9793	Fax insurance referral, clinic note from referral source and all relevant records.	205.638.9790 Option 1
Rheumatology	205.638.2833	Fax all relevant* lab, imaging results and records. Please include appointment date and time.	205.638.9438
Sleep Medicine	205.638.2466	Please attach patient history.	205.638.9386
Sports Medicine	205.975.6109	Fax all relevant* information, including demographic and insurance information. Send x-ray or MRI films to the appointment with the patient.	205.934.1041
Surgery (General)	205.975.4972	Fax referrals and all relevant* records, labs, MRIs and CTs.	205.638.9688
Urology	205.975.6024	Fax all relevant* records and labs. Send x-ray, CT, MRI films with patient to appointment.	205.638.9840
Weight Management	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.	205.638.5750

