

Mary Bridge Referral Fax

FAX REFERRAL TO 253-864-3939



Date of request: _____

URGENT Request

PATIENT INFORMATION

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

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

Address: _____ Insurance Payor and Plan: _____

Subscriber Name and ID Number: _____ Guarantor: _____

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

attach a copy of insurance card confirmed patient demographics are current

TO REACH AN ON-CALL SPECIALTY PROVIDER – CALL 1-855-647-1010

REFERRAL REQUEST INFORMATION

Referring Provider: _____

Contact Person and Phone Number for Referring Office: _____ (____) ____ - ____

Primary Care Provider: _____

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 the below with the referral:

<p>Neurology</p> <ul style="list-style-type: none"> <input type="checkbox"/> All imaging related to referral <input type="checkbox"/> Growth chart & head circumference, if available <input type="checkbox"/> Any available outside specialist notes related to Neuro concerns <input type="checkbox"/> Any available genetic test results <input type="checkbox"/> Any available behavior assessments <p>Audiology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing evaluation notes if one has been done <input type="checkbox"/> For already established hearing aids; previous audiologic reports/hearing aid information, if available 	<p>Physical Medicine & Rehab</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chart Notes <input type="checkbox"/> Birth history <input type="checkbox"/> Imaging (MRI's), if completed <input type="checkbox"/> PT/OT/Speech notes <input type="checkbox"/> IEPs from school <input type="checkbox"/> Genetic notes <input type="checkbox"/> Neuro Develop Testing 	<p>Gastroenterology</p> <ul style="list-style-type: none"> <input type="checkbox"/> All imaging related to referral <input type="checkbox"/> Labs related to referral <input type="checkbox"/> Growth chart <p>Urology</p> <ul style="list-style-type: none"> <input type="checkbox"/> All imaging related to referral 	<p>Genetics (referral required)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Growth Charts & Head Circ. <input type="checkbox"/> Imaging studies <input type="checkbox"/> Previous Genetic Testing <input type="checkbox"/> Signs & Symptoms for Referral <input type="checkbox"/> Family history of XXX, genetic test reports or clinical records from affected family member 	<p>No Additional Info Required for these Specialties:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cardiac Surgery <input type="checkbox"/> General Surgery <input type="checkbox"/> Neonatal Follow Up <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthotics <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Plastic & Reconstructive Surgery <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Pulmonology <input type="checkbox"/> Wound Ostomy <input type="checkbox"/> Child Life Services
<p>Endocrinology</p> <ul style="list-style-type: none"> <input type="checkbox"/> All imaging related to referral <input type="checkbox"/> Labs related to referral <input type="checkbox"/> Growth chart <p>Nutrition</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head circumference <input type="checkbox"/> Growth chart 	<p>Hematology & Oncology</p> <ul style="list-style-type: none"> <input type="checkbox"/> All imaging and chart notes related to referral (newborn screen if applies) <p>For Urgent Hem/Onc Referrals call: 253-403-3481</p>	<p>Occupational Therapy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assistive Technology <p>ENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current audiology report or hearing exam results 	<p>Orthopedics</p> <ul style="list-style-type: none"> <input type="checkbox"/> Date of Injury ____ / ____ / ____ <input type="checkbox"/> Is it an MVA? <input type="checkbox"/> Current images/or where images were taken? <input type="checkbox"/> PT or other notes 	<p>Neurobehavioral Medicine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Developmental Behavioral <input type="checkbox"/> Neuropsychology <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychology
<p>Rheumatology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chart notes related to referral <input type="checkbox"/> Imaging related to referral <input type="checkbox"/> Labs related to referral 	<p>Infectious Diseases</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chart notes <input type="checkbox"/> Imaging <input type="checkbox"/> Labs 	<p>Nephrology</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urine & Labs <input type="checkbox"/> All imaging related <input type="checkbox"/> Growth chart <input type="checkbox"/> Blood pressure records 	<p>For Referral Support call: 253-792-6630</p>	

Once we receive your referral, we will attempt to make contact with your patient to schedule the appointment. **Thank you for your referral!**