

WakeMed Children's Specialty Services: *(Please check specific practice for referral)*



Pediatric Cardiology
Appointments: 919-235-6422
Fax: 919-231-0314

Pediatric Thyroid Center
Appointments: 919-350-7584
Fax: 919-231-0314

Pediatric Endocrinology
Appointments: 919-350-7584
Fax: 919-231-0314

Pediatric Urology
Appointments: 919-235-1940
Fax: 919-235-1325

ENT – Head & Neck Surgery
Appointments: 919-350-1630
Fax: 919-350-9812

Pediatric Gastroenterology
Appointments: 919-235-6422
Fax: 919-231-0314

Pediatric Weight Management
Program includes: nutrition, psychological counseling, community based exercise

Wake Orthopaedics – Pediatric Orthopaedist
Appointments: 919-232-5024
Fax: 919-232-5028

Pediatric Pulmonary and Sleep Medicine
Appointments: 919-235-6535
Fax: 919-231-0314

Weight Management Referral or
 Lipid Management Referral

Appointments: 919-235-6439
Fax: 919-231-0314

Please visit www.wakemed.org/physician-practices for provider information and practice address.

Pediatric Surgery
Appointments: 919-350-8797
Fax: 919-350-7859

Do you want this patient scheduled with a specific provider?

Yes No If so, with whom: _____

REQUEST FOR CONSULTATION

PATIENT DEMOGRAPHIC INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: M F Race: _____

Address: _____ City/State/Zip: _____

Phone *(Please circle preferred number)* Home: _____ Cell: _____ Work: _____

Email: _____

Does patient/family need an interpreter? No Yes If yes, please specify language _____

INSURANCE INFORMATION

Insurance Name: _____

Policyholder's Name: _____ Policyholder's Date of Birth: _____

Insurance Phone: _____ Policy Number: _____ Group Number: _____

Medicaid Authorization NPI: _____ Authorized Number of Visits: _____

Care referral authorization initiated

REFERRAL INFORMATION

Reason for Referral: _____

Pertinent History: _____

Symptoms: _____

REFERRING PHYSICIAN INFORMATION

Name: _____

Practice Name (if applicable): _____

Address: _____

City/State/Zip: _____

Office Phone: _____ Fax: _____

Name of Person completing this form: _____

- Please include with referral (all that are applicable)**
- History/Office Notes
 - Labs
 - Imaging Studies (patient should bring films or CD)
 - Other pertinent medical records

Thank you for referring your patient to WakeMed Children's Services