

Request for Chest Wall Center Consultation

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

Do you want this patient scheduled with a specific provider? Yes No

If so, with whom: _____

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: _____

If patient is less than 18 years, Guardian Name: _____ Guardian Date of Birth: _____

Guardian 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
- Growth Charts
- Labs
- Imaging Studies (patient should bring films or CD)
- Other pertinent medical records

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