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

WakeMed Children's

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

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

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

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

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

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

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

☐ **Pediatric Weight Management Program (BMI ≥ 95th%ile)**
Program includes: nutrition, psychological counseling, community-based exercise **(ie. ENERGIZE)**

☐ **Weight Management Referral** or
☐ **Lipid Management Referral**

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

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

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

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: _____

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: _____

_____

Symtoms: _____

_____

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