MISSION CHILDREN'S SPECIALIST REFERRAL
Phone #: (828) 213-1740 (main number)
Fax #: (828) 213-1742

❑ **Endocrinology**

❑ **Pulmonology**

❑ **Neurology**

❑**Nutrition**

❑**Orthopedics**

❑**General Surgery**

❑ **Pediatric Advanced Care Team**

❑ **Gastroenterology**

**Patient Name**: _____ ___ _____ **DOB:** _____**Age:** ____ **Sex:** ____
(First) (MI) (Last)

**Mailing Address**: _____, _____, _____, _____
(Street-PO Box) (City) (State) (Zip)

**Mother/Father/Guardian Name(s):**_____

**Home Phone**: (____) _____ **Mother/Guardian Cell#**: (____) _____ **Mother/Guardian Work#:** (___) _____

**Father/Guardian Cell#:** (_____) _____ **Father/Guardian Work#:** (____) _____

**Name of Other Contact** _____ **Other Contact Phone#:** _____
**Relationship:** _____

**Referring Healthcare Provider**:
_____

**Primary Care Physician (if other than referring):**
_____

***** Please Send Insurance Information With Referral*****

**Is an interpreter needed? YES □ NO □** – If yes, language_____

**Medical Reason for Consult**: _____

**What other providers have seen this child for this concern or diagnosis**: _____

**Current Medications:** _____

******To assist us in caring for your patient, please send information below with referral. Scheduling of appointments will be postponed until pertinent information is received.******

* INSURANCE CARD/INFORMATION
* GROWTH RECORDS & GROWTH CHARTS
* INFORMATION PERTINENT TO CONCERNS
* RELEVANT / MOST RECENT OFFICE NOTES
* PREVIOUS SPECIALTY EVALUATIONS
* LABORATORY & RADIOLOGY STUDIES

**PLEASE RATE URGENCY OF YOUR REFERRAL:** Routine Urgent

**Referring Physician Office contact name**: _____ **Fax Number:** (_____) _____

**PROVIDER SIGNATURE:** _____ **Date:** _____