



REQUEST FOR SPECIALTY SERVICES

FAX form to 513-803-1111 or 1-866-877-8905

3333 Burnet Ave., MLC 9014
Cincinnati, OH 45229-3039
1-800-344-2462

Forms: www.cincinnatichildrens.org/consults

(After faxing form, encourage family to call for appointment.)

PATIENT INFORMATION

Patient's name _____ CCHMC MR # _____
(If available)
Date of Birth _____ Home Phone _____ Alt Phone _____

REASON FOR REQUEST

Reason for request / Specific question(s) to be answered:

- _____
- _____

History / Symptoms / Potential diagnosis / Special needs: _____

Check here if additional clinical information is included with this request.

SERVICES REQUESTED

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Weight Gain | <input type="checkbox"/> Diabetes ¹ | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Adolescent Medicine/Teen Health Center | <input type="checkbox"/> Diagnostic Clinic | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> Aerodigestive | <input type="checkbox"/> Endocrinology ¹ | <input type="checkbox"/> Nutrition ¹ |
| <input type="checkbox"/> Allergy Clinic | <input type="checkbox"/> ENT (Otolaryngology) | <input type="checkbox"/> Ophthalmology/Eye Clinic |
| <input type="checkbox"/> Audiology (Hearing) | <input type="checkbox"/> Feeding Team | <input type="checkbox"/> Orthopaedics |
| <input type="checkbox"/> Behavioral Medicine & Clinical Psychology | <input type="checkbox"/> Fetal Surgery | <input type="checkbox"/> Perleman Center/United Cerebral Palsy |
| <input type="checkbox"/> Brachial Plexus Clinic | <input type="checkbox"/> Gastroenterology-GI ¹ | <input type="checkbox"/> Physical Medicine & Rehabilitation |
| <input type="checkbox"/> Breast Feeding Clinic | <input type="checkbox"/> Gynecology (Pediatric & Adolescent) | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Healthworks! ¹ | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Hemangioma & Vascular Malformation Team | <input type="checkbox"/> Pulmonary Medicine |
| <input type="checkbox"/> Chronic Pain Management | <input type="checkbox"/> Hematology-Oncology ¹ | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Colorectal Surgery | <input type="checkbox"/> Human Genetics | <input type="checkbox"/> Sleep Center |
| <input type="checkbox"/> Comprehensive Weight Management Center | <input type="checkbox"/> Hypertension / Cholesterol Clinic | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Craniofacial Center | <input type="checkbox"/> Infectious Diseases-ID ¹ | <input type="checkbox"/> Surgery (General & Thoracic Surgery) |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> International Adoption Center-IAC | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Mayerson Center for Safe & Healthy Children | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Developmental & Behavioral Pediatrics | <input type="checkbox"/> Nephrology | |

¹ Please include copy of patient's growth charts.

Do you want this patient scheduled with a specific provider? Yes No If so, with whom? _____
(Note: Requesting a specific provider may cause delays in appointment scheduling.)

It is Cincinnati Children's goal to have routine appointments available within 10 days; however, not all divisions have achieved this goal. If it is medically necessary for this patient to be seen urgently by a physician, call Physician Priority Link 888-636-7997.

REQUESTING PRACTITIONER / GROUP

Office Name _____ Physician Name _____
Office Address _____ Telephone _____
Fax _____

