PHYSICIAN REFERRAL FAX REQUEST FOR EVALUATION IN THE EMERGENCY DEPARTMENT

(NOT for use when referring patients to a CCHMC urgent care site)

Fax to 513-636-4050 Please call 513-636-1111 Option #2 to confirm receipt of Fax Referral has been received

REQUIRED INFORMATION FOR REFERRAL

Patient's CCHMC Medical Record Number **OR** **Patient First Name** _____

_____ **Patients Last Name** _____

Select Appropriate Facility **Patient DOB:** _____

☐ **Burnet Campus** **Gender:** ☐ Female ☐ Male

☐ **Liberty Campus** **Name of Patient's Parent/Legal Guardian**

_____

Chief Complaint/Reason for Referral: _____

Refer To: ☐ Emergency Medicine ☐ Emergency Medicine + consult ☐ Sub specialist/other ☐ Test Only

***You must notify any consultants/sub specialists before initiating a referral to the Emergency Department*.**

Sub specialist/Consultant Name: _____ **Service:** _____

Pager/Phone Number: _____ or ☐ page on-call physician/resident

Referring Physician: _____**Office/pager** (_____)_____

After Hours ____:____ **AM/PM Call** (_____)_____

Callback Instructions: ☐ After MD assessment (prior to labs and tests) ☐ After ED evaluation

☐ Only if concerns or admitted ☐ No callback requested

Callback Physician: ☐ Same as referring physician ☐ On call for practice

Callback Phone Number: ☐ Same as office number ☐ Same as after hours number

☐ Other (_____)_____

Call back after six hours if patient does not arrive? (Calls are made between 9 AM and midnight) ☐ Yes ☐ No

Patient Transferred From: ☐ Home ☐ MD office ☐ Other: _____

Clinical information (use additional sheets if necessary): _____

_____

_____

_____

Labs/X-rays/Treatments

☐ CBC ☐ Blood culture ☐ Urinalysis ☐ Urine culture ☐ Lumbar puncture

☐ Electrolytes ☐ Chest-x-ray ☐ IV fluids ☐ Other_____

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