Cincinnati Children's
changing the outcome together

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.

Date: _____ Time: _____

REQUIRED INFORMATION FOR REFERRAL

Patient's CCHMC Medical Record Number: *(if available)*

_____

Patient first name: _____

Patient last name: _____

Patient DOB: _____

Select appropriate facility:
☐ Burnet Campus
☐ Liberty Campus

Gender: _____

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? ☐ Yes ☐ No
(*Calls are made between 9 AM and midnight*)

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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