

Pediatric One-Call Center New Patient Referral Form

Date: _____

Please complete this form in its entirety and fax it to 203-737-7635 along with pertinent medical records.

Note: All services listed below are included in the One-Call Program. See FAQ Sheet for other Pediatric Programs.

Consult Requested For (check all that apply):

Adolescent Comprehensive Care

- Eating Disorders

Adoption (see Developmental & Behavioral)

Aerodigestive Program

- Aerodigestive - ENT
- Aerodigestive - GI
- Aerodigestive - Respiratory Medicine
- Aerodigestive - Surgery

Allergy/Immunology

- Allergy
- Immunology

Cardiology

- Adult Congenital Heart
- Arrhythmia/Pacemaker
- Cardiogenetics
- General Cardiology
- Heart Failure
- Kawasaki Disease

Developmental & Behavioral

- Adoption/Foster Care
- Autism
- Young Child DBP Problems
- School Age DBP Problems

Endocrinology

- Gender Center
- General Endocrinology
- Metabolic Bone Disorders
- Obesity/PCOS
- Type 1 Diabetes
- Type 2 Diabetes

GI/Hepatology

- Celiac Disease
- General GI
- Hepatology/Metabolic Liver
- Inflammatory Bowel Disease

Hematology/Oncology

- Bone Marrow Transplant
- Coagulation Disorders
- General Hematology
- General Oncology
- Hemophilia
- HEROS/Survivors Clinic
- Neuro-Oncology
- Sickle Cell

Infectious Diseases

- General Infectious Diseases
- Pediatric Immunology (HIV)

Integrative Medicine

- Adult & Pediatric Integrative Medicine

MDA/Neuromuscular

- MDA - Cardiology
- MDA - Neurology
- MDA - Orthopedics
- MDA - Respiratory

Neonatal-Perinatal Medicine

- NICU GRAD Program

Nephrology

- Dialysis Management
- General Nephology
- Kidney Transplant

Neurology

- General Neurology
- Headaches
- Movement Disorders
- Spina Bifida
- Stroke

Respiratory Medicine

- Asthma
- BPD
- CF
- CPAP/BiPAP
- Exercise Induced Bronchoconstriction
- General Respiratory
- Sleep Disorders

Rheumatology

- General Rheumatology

Spina Bifida (see Neurology)

Toxicology

- Lead Clinic

Patient Name: _____ **Gender:** M F **DOB:** _____

Address: _____

Parent/Guardian Name(s): _____

Phone: (Home) _____ **(Work)** _____ **(Cell)** _____

Primary Language if other than English: _____ **Interpreter Req:** Yes No

Brief Medical History/Reason for Referral: _____

Medications: _____

PCP/Referring Provider Name: _____

Address: _____ **Phone:** _____ **Fax:** _____

For additional copies, go to: (<http://yalemedicine.org/refer/pediatricspecialty/> or <http://pediatrics.yale.edu>).

Yale Pediatric Call Center - Phone: 203-785-4081/Fax: 203-737-7635