Yale SCHOOL OF MEDICINE

YALE-NEW HAVEN CHILDREN'S HOSPITAL

PEDIATRIC SURGERY NEW PATIENT REFERRAL FORM

Date: _____

1. **PHONE OPTION/APPOINTMENT CONFIRMATION: Please call 203-785-2701** to schedule an appointment for the following providers:

Dr. Michael Caty	Dr. Robert Cowles
Dr. Emily Christison-Lagay	Dr. David Stitelman
Dr. Doruk Ozgediz	Dr. Catherine Dinauer (Pediatric Endocrinology/Tyroid Disorders)

2. **FAX OPTION/APPOINTMENT REFERRAL:** Please complete this form in its entirety. For all refherrals, please provide a brief medical history, current medications, growth chart, and any relevant lab and/or radiology reports via **fax to 203-785-3820**.

3. **PATIENT INFORMATION:**

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

Address (1): _____

Address (2): _____

Parent/Guardian Name(s): _____

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

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

Insurance Company Name: _____ **ID #:** _____

Brief Medical History/Reason for Referral: _____

_____

_____

Medications: _____

_____

Labs/Diagnostic Imaging/Records (Please indicate below records you are faxing with this form)

□ Blood work	□ Cardiac Tests	□ Neurologic Testing
□ Stool studies/ Urinalysis	□ Immunization Records	□ X**-ray/other diagnostic imaging***
□ Pertinent Office Records/Growth Charts	□ Other (specify): _____	

***Please forward the discs to our office, Pediatric Surgery, 333 Cedar Street, PO Box 208062, New Haven, CT 06520**

PCP/Referring Provider Name: _____

Address: _____

Phone: _____ **Fax:** _____ **E-mail** (optional): _____

For Yale Office Use Only

Appointment Date: _____ Appointment Time: _____ Scheduled Provider: _____

Parent/Guardian Notified: □**Yes** □**No:** Conversation:____ Message: _____ Date: _____ Initials: _____