Maine Medical PARTNERS

207-662-5522

PEDIATRIC SPECIALTY CARE & PEDIATRIC SURGERY CONSULTATION REFERRAL FORM

Patient Information: **Date:**_____

Patient Name:_____ SS#:_____DOB: _____

Sex: _____Preferred Name: _____ Gender: _____

Parent/Guardian Name:_____

Mailing Address:_____

Phone #:_____ Alternate Phone #_____

Insurance/ Referral Information Must Be Filled Out Completely

*PCP Name:*_____ *NPI #*_____*MaineCare#*_____

*PCP Contact Person:*_____ *Phone:*_____ *Fax:* _____

*Reason for Consultation:*_____

Insurance: _____*Policy #:*_____ *Group:* _____

Subscriber Name: _____ *DOB:*_____ *Employer:*_____

*Referral # (if HMO and needed):*_____*Number of visits authorized:* _____

Referred to: _____ *From Date:*_____ *To Date:*_____

Please send: ☐ ***Recent Notes*** ☐ ***Lab Reports*** ☐ ***Radiology Reports***
☐ ***Insurance Card Copy*** ☐ ***Growth Charts*** ☐ ***Other Pertinent Information***

Check one and Fax to:

☐ Endocrinology	662-5524	☐ Pulmonology	662-5527
☐ Gastroenterology	662-5526	☐ Genetics	774-1814
☐ Infectious Disease	662-5526	☐ Diabetes	662-5524
☐ Nephrology	662-5777	☐ Pediatric Surgery	662-5526
☐ Gender Clinic	662-5528	☐ Countdown	772-3098

☐ Developmental/Behavioral 774-1814

☐ First available provider in specialty ☐ Requested provider:_____

TO BE COMPLETED BY STAFF AT PSC

☐ **Consultation Accepted: Appt. Date:**_____ **Time:**_____ **Provider:**_____

☐ **Confirmation packet sent, including directions** **Clinic Location:**_____

☐ **More Information Needed:**_____☐ **Consultation rejected because:**_____

Comments:_____

Thank you for your Consultation Request. You should hear from us within five business days.