



**Seattle Children's**  
HOSPITAL • RESEARCH • FOUNDATION

# New Appointment Request Form

Please call our Clinical Intake nurses at **206-987-2080** or fax this completed form with pertinent clinical information to **(206) 985-3121**.

Please review the Consult and Referral Guidelines at <http://medicalstaff.seattlechildrens.org> to help ensure timely and appropriate coordination of care. **New federal guidelines require your request to clearly indicate if this is a consult versus a referral (transfer of care).**

**For emergent requests: Please contact the appropriate on call provider at (206) 987-7777 to discuss emergent issues or alternate resources. Psychiatry patients in emergent crisis should be referred to the Crisis Outreach Response System at 206-461-3222.**

Date of referral:	
Patient last name:	First: MI:
Date of birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/guardian name:	Best contact phone(s):
Zip code:	State of residence (if not Washington): <input type="checkbox"/> AK <input type="checkbox"/> MT <input type="checkbox"/> ID <input type="checkbox"/> Other:
Insurance Plan:	Interpreter needed? <input type="checkbox"/> Yes Language:
<b>Clinic Requested:</b>	To expedite new schedule requests patients may be seen by a nurse practitioner, physician assistant or other provider unless you indicate this is not acceptable. Check here if you request MD only: <input type="checkbox"/> MD ONLY
<b>Please check one</b> <input type="checkbox"/> <b>I request your consultation for the following question:</b>  <input type="checkbox"/> <b>I would like to transfer care for the following health issue:</b>	<b>Category of Request (Check all that apply):</b> <input type="checkbox"/> Diagnostic Evaluation <input type="checkbox"/> Medical Management <input type="checkbox"/> Medication Evaluation/Management <input type="checkbox"/> Mental Health Therapy <input type="checkbox"/> Surgical Options/Opinion <input type="checkbox"/> Telemedicine/Preferred site: _____ <input type="checkbox"/> Other:
<b>Previous/current relevant health or mental health history (include duration of symptoms):</b> <i>And fax all relevant chart notes, clinical history, lab results, tests/therapy/medication history to (206) 985-3121</i>	
Requesting provider:	<input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Other
Best contact number:	Fax:

**NOTE: Group Health, Molina, or Tricare insurance subscribers and mental health requests always require pre-authorization prior to scheduling.**

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