Seattle Children's
HOSPITAL • RESEARCH • FOUNDATION

New Appointment Request Form

Please fax this completed form, patient demographics, and last clinic note to **(907) 339-1994** or email **alaskacardiology@seattlechildrens.org**.

Pediatric Cardiology of Alaska

For **urgent requests** for appointment or to speak with our on call provider**,** call our office **(907) 339-1945**.
For clinical questions regarding referrals, please call our office and request to speak with the nurse.

☐ Routine ☐ Urgent

Date of referral:	Best contact phone(s):
Patient last name:	First: Middle:
Date of birth:	Sex: ☐ Male ☐ Female
Mother's last name at birth:	Previous legal name:
Parent/guardian name:	Insurance Plan: ID #:
Primary caregiver's email address:	Interpreter needed? ☐ Yes Language:
Preferred Clinic Location: If the preferred clinic is a location other than Anchorage, is it acceptable to wait until our next outreach clinic? **Yes** or **No** If no, we will schedule the appointment in Anchorage. ☐ Anchorage ☐ Ketchikan ☐ Barrow ☐ Kodiak ☐ Bethel ☐ Nome ☐ Dillingham ☐ Sitka ☐ Fairbanks ☐ Soldotna ☐ Juneau ☐ Wasilla	**Services Requested:** ☐ Clinic visit with cardiologist **OR** ☐ ECG only ☐ Holter monitor only ☐ Schedule future clinic visit with cardiologist if results abnormal
Clinical reason for this referral including relevant health history:	**Referring Provider**_____ Phone Number:_____ Fax Number:_____ ☐ I am the Primary Care Provider ☐ Other_____

Please review the Clinic Referral Information at http://www.seattlechildrens.org/referralinfo/ *to help ensure timely and appropriate coordination of care.* ***Federal guidelines require your request to clearly indicate if this is a consult versus a referral (transfer of care).***

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

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