Kids Kare Pediatric Cardiology

REFERRAL FORM

Instructions:

Please FAX the completed form to **(931) 526-5084**, Attention: Front Desk receptionist Please send a copy of the front and back of the insurance card, if available.	**TODAY'S DATE:**

PATIENT INFORMATION (please print)

Patient Name:	Date of Birth:	Gender:
Street Address:	City & State:	Zip Code:
Parent / Guardian Name :	Home/Cell Phone Number:	Relationship to Patient:
Insurance Name/plan :	Group Number:	Effective Date:
Subscriber Name :	Subscriber ID# :	Subscriber Date of Birth :
PCP Name if not Referring Physician :	Office Name :	Phone Number:

REFERRING PHYSICIAN INFORMATION

Referring Provider's Name: ☐ MD ☐ NP ☐ DO ☐ PA	Name of Person filling out this form:	
Practice Name:	Phone Number:	Fax Number:
Address:	City & State:	Zip Code:

APPOINTMENT REQUEST:

Requested Provider & Specialty: **CHRISTOPHER D. CLIMACO, M.D. - PEDIATRIC CARDIOLOGIST**
Reason for Referral (diagnosis or symptoms): Please submit PERTINENT medical records, EKG, imaging & lab test results. DO NOT enter ICD codes here.

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS SECTION

Date of Appointment:	Time of Appointment:	Scheduled by: (Kids Kare staff)	

Please call us at 931-526-6173 if you have any questions.

Thank you for referring your patient to Kids Kare Pediatric Cardiology.