CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

Pediatric Specialty Services

Additional Referral Materials

Date _____

To Specialty Department: _____

From:

Referring MD _____

Best way to reach me is by ☐ Phone ☐ Fax ☐ Email ☐ Pager

Phone _____ Fax _____

Email _____ Pager _____

For Patient:

Patient's First Name _____ Last Name _____

DOB _____ / _____ / _____ Gender ☐ Female ☐ Male

Attachments:

Sending this information helps us give your patient the most effective care.

☐ Medical Record Notes

☐ Growth Curves

☐ Pertinent Operative Note

☐ Results of Diagnostic/Imaging Studies

☐ Pertinent Lab Studies

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ Other: _____

Notes:

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