



# WOMEN & CHILDREN'S HOSPITAL OF BUFFALO

A Kaleida Health Facility

219 Bryant Street • Buffalo, NY 14222

## Consultation/Referral

### Intent of Requesting Physician/Group

#### CONSULTATION

Evaluate, Advise and/or assist with diagnosis and management

#### REFERRAL

Assume total management for this known problem

Date: \_\_\_\_\_

Time: \_\_\_\_\_

### Services Requested/Requesting Physician Group Practice

TO: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

FROM: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### Patient Information

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_<sup>Street</sup> Work/Cell Phone: \_\_\_\_\_<sup>City</sup> \_\_\_\_\_<sup>State</sup> \_\_\_\_\_<sup>Zip</sup>

(WCHOB MR NO. if known)

### Reason for Referral

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Significant PMH/SH

### Current Medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Labs /Diagnostic Imaging (See Attached)

\_\_\_\_\_  
\_\_\_\_\_

### Specialist Summary of Findings/Recommendations

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician/Specialist

Insurance verification attached

*Thank you for seeing this child. I look forward to your recommendations.*