Children's Mercy HOSPITALS & CLINICS
www.childrensmercy.org

Physician Appointment Line / Contact Center
Phone 816-234-3700 (office use only) or toll free 1-800-800-7300
Fax 816-855-1776

APPOINTMENT and MEDICAL RECORDS FAX FORM (For Physican Use Only)

***PLEASE CHECK*:** ☐ **New Appointment** ☐ **Medical Records Only** (Follow-up or Appointment has already been made)

******PLEASE PRINT LEGIBLY******

Referring Physician:______________________ Office Fax:______________________

Office Contact Name:______________________ Office Phone:______________________

Patient Name:______________________ DOB:______________ M F

Parent or Guardian's Name:______________________ Home Phone:______________________

Address:______________________ Alt. Phone:______________________

City:__________________ State:__________ Zip:______________

****Can we leave a message at the home/alt. phone? Y N** Translator Needed? **Y N** Language______________

Reason For Referral/Symptoms____

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____

Onset of Illness/Injury:______________________

Has Lab been done? **Y N** If yes, please include results with fax.

Has Radiology been done? **Y N** If yes, please include results with fax.

Please be as detailed as possible to ensure appropriate clinic and appointment slot.
Note size and location of lesions- particularly vascular.

Is there a location preference: **Children's Mercy Main** **Children's Mercy South** **Children's Mercy Northland**

PLEASE CIRCLE:

Allergy/Asthma	Genetics	Neurology	Pulmonology	Other:
Cardiology	GI	Neurosurgery	Rehab/Spec Care	
Dermatology	GYN	Nutrition	Rheumatology	
Endocrine	Hearing & Speech	Ophthalmology	Sleep Disorders	☐ **Check here if you are faxing Medical Records only. Circle the Department that needs the reports or write the Department name in *Other* if not listed.**
ENT	ID	Orthopedics	Teen Clinic	
****If Otitis Media Must fill out below**	Kidney/Nephrology If Enuresis circle Day or Night	OT/PT	Urology Surgery	
		Pain Management	Weight Management **HT_____ WT_____**	
General Surgery		Plastic Surgery		

****Otitis Media if Child is 3 years and Younger**: Hearing test within 4 weeks shows hearing loss? **Y N**
3 Diagnosed ear infections in 6 mos. or 4 in 12 mos? **Y N** Current infection? **Y N**

Note: Hematology/Oncology must be a Doctor to Doctor referral. Clinic # 816-234-3265
Developmental/Behavioral is scheduled by parent. Have them call the Clinic at 816-234-3674

Outpatient Procedures

Note: Routine x-rays **do not** need an appointment. Patients need to bring physician's order to the Radiology Dept. or include and it will be faxed to the dept. Radiology 816-234-3270

CT Scan of ______________________ **with contrast** or **without contrast**	Nuclear Medicine- please include height and weight HT ____________ WT ____________
Ultra Sound Type: ______________________	MRI Type:______________________ Reason:______________________
VCUG	Neurophysiology-EEG 816-234-3092
Physician Order______________________	**Physician Signature**______________________ **(required for all procedures)**

Please fax a copy of insurance card(s) with this form.

Note: Each patient is given a "next available" appointment slot. If scheduled appointment is not soon enough please let us know.

Updated 9/2/10