Driscoll Children's Hospital

Referral/Order Form

Pediatric Cardiology - El Paso

REASON FOR REFERRAL - DESCRIPTION AND CODES *(Please include the ICD10 code for the sign/symptom/diagnosis)*

Diagnosis description and ICD10 codes *(When appropriate, specify laterality, site, encounter type, cause of injury.)*

_____

_____

Procedure or exams to be performed - description and CPT code:

_____

_____

PATIENT INFORMATION *(Supply here or fax patient face sheet with this information)*

Name: _____ ☐ Male ☐ Female Date Referred: _____

Date of Birth: _____ Social Security Number: _____

Address/City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Other: _____

Father's Name: _____ Date of Birth: _____ Phone: _____

Mother's Name: _____ Date of Birth: _____ Phone: _____

Legal Guardian/Relationship: _____ Date of Birth: _____ Phone: _____

PROVIDER INFORMATION

Primary Care Physician: _____ Phone: _____

Referring Physician *(if different)*: _____ Phone: _____

Referring Physician's NPI #: _____

INSURANCE CARDS *(Fax copies of insurance card or provide information below)*

Primary Insurance: _____ **Group #:** _____

Member ID/Medicaid/Medicare Number: _____

Subscriber Name: _____ Date of Birth: _____ Subscriber ID #: _____

Primary Insurance Phone: _____

Secondary Insurance: _____ **Group #:** _____

Member ID/Medicaid/Medicare Number: _____

Subscriber Name: _____ Date of Birth: _____ Subscriber ID #: _____

Secondary Insurance Phone: _____

AUTHORIZATION INFORMATION *(or include fax doc.)*

Authorization: ☐ Not Required ☐ Requested/Obtained:

_____

AUTHORIZATION # ('S):

_____ _____

Referring Physician's Signature *Date*

driscollchildrens.org/refer

REFERRAL MANAGEMENT

Phone: (915) 275-1510 **Fax:** (915) 745-1634 **Email:** CPAS_Referral.Management@dchstx.org