DRISCOLL HEALTH SYSTEM

Referral/Order Form

www.driscollchildrens.org/refer

Specialty _____

Specific provider _____

☐ First available

Location

☐ Corpus Christi ☐ McAllen ☐ Brownsville ☐ Harlingen

☐ Laredo ☐ Victoria Other (please note) _____

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/ST/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: _____ DOB: _____ Subscriber ID Number: _____

Primary Insurance Phone #: _____

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

Member ID/Medicaid/Medicare Number: _____

Subscriber Name: _____ DOB: _____ Subscriber ID Number: _____

Secondary Insurance Phone #: _____

AUTHORIZATION INFORMATION *(or include fax doc.)*

Authorization: ☐ Not Required ☐ Requested/Obtained:

Authorization # ('s):

_____

Referring Physician's Signature Date

Referral Management:

Phone: (361) 431-3140

Toll-free Phone: (844) 431-3140

Email: CPAS_Referral.Management@dchstx.org