AT THE FOREFRONT OF KIDS' MEDICINE
UChicago Medicine
Comer Children's

REFERRAL FORM

Please send completed form & medical records to Brooke Hernandez via

- Email: Brooke.Hernandez@uchicagomedicine.org| fax: 773-751-0680
- Phone: 773-573-9500

Referring Physician Information:

Physician Name: Date:

Would referring MD like direct contact from UChicago Medicine MD regarding this patient: ☐ YES ☐ NO (if yes, please provide info below)

Physician cell number / email:

Practice Name:

Practice Phone: Practice Fax:

Practice Contact:

Patient Information:

Patient Name: ☐ Male ☐ Female

Date of Birth: Interpreter needed: ☐ YES ☐ NO

Parent Name:

Home Number: Cell Number:

Address: City: State: Zip:

Email Address:

Insurance: Group: ID:

Policy Holder: Policy Holder DOB:

Referral Request:

Patient Diagnosis: Newly Diagnosed: ☐ YES ☐ NO

Specialty Requested: Physician Requested:

Interest in Clinical Trial: ☐ YES ☐ NO Seeking Second Opinion: ☐ YES ☐ NO

Please provide location of testing:

Pathology Location: Imaging Location:

Confirmation: If you are not contacted within 24 hours of faxing this form, please call Brooke Hernandez at 773-573-9500

Thank you for this referral and for trusting the physicians and medical staff at UChicago Medicine Comer Children's to serve as an extension of the care you provide your patients.