THE University of Vermont Children's Hospital

MRN

Name

DOB

Addressograph

Cleft Craniofacial Referral Form

Phone # 802-847-3340
Fax # 802-847-7083

Patient Name: _____DOB: _____ Sex: _____

Address: _____

Parent/Guardian's Name: _____

Phone #: (H):_____ (M):_____ (W):_____

Referring Provider: _____

Phone#: _____ Fax: _____

Patient's PCP (If different than Referring Provider): _____

Reason for Referral: _____

Is referral urgent? (Please circle) **Yes** **No** if yes- please state why: _____

_____

Has the patient ever been seen by a specialist for this problem before? (Please circle) **Yes** **No**

If yes- who, where, and when _____

Is the patient's family aware of this referral? (Please circle) **Yes** **No**

Has any imaging or testing been done related to this problem? (Please circle) **Yes** **No**

If yes- Please specify where and when the following were completed:

Imaging (Ultrasound, CT, MRI, etc.): _____

Labs: _____

Other: _____

Please forward all records with intake form
All imaging needs to be sent electronically or mailed at time of referral

Insurance Information - must be completed for an appointment to be scheduled:

Does this appointment require a referral? (Please circle) **Yes** **No**

Primary Insurance Co: _____ Secondary Insurance Co: _____

Policy#: _____ Policy#: _____

Phone#: _____ Phone#: _____