Referral Form

Gillette Children's Specialty Healthcare

For routine referrals, fax completed form to 651-726-2622. For urgent referrals (appointment within two weeks), provider should call our One Call nurse directly at 651-325-2200.

Choose the Type of Referral *
❒ Diagnose and Treat (Co-Manage)
❒ Consultation
❒ Transfer of Care
❒ Allied Health Referral (Rehabilitation Therapies, Orthotics and Prosthetics, Seating, Psychology)

Please consult with me, the primary care provider, before making secondary referrals.
❒ Yes
❒ No

Provider Information

UPIN Number / NPI *

Referring Provider Name *

Referring Provider Email Address

Primary Care Provider (❒ Same as Referring Provider)

Clinic Information

Clinic Name
sankara eye hospital

Street Address
shankar nagar

Address Line 2
poonamalle

City
chennai

State / Province / Region

600098
Postal / Zip Code

Country
india

Clinic Phone Number
099987876542

Clinic Fax Number
4567-9987-77897

Additional Contact Name
poorani

Additional Contact Phone Number

Patient Information

Is family/patient aware of the referral? Yes ■ No ❒
If No, please make them aware as soon as possible.

Patient Name *
ranjith kumar .N

Date of Birth *

Gender*
■ Male
❒ Female

Patient Address
no:145, vallalar street, voc nagar, villupuram-678990

Street Address
vallalar street

Address Line 2
villupuram

City
villupuram city

State / Province / Region

678990
Postal / Zip Code

Country
tamilnadu

Primary Contact
india

Relationship to Patient
9988765778

Primary Phone Number
wife

Alternative Phone Number

Preferred Language
tamil

Preferred Gillette Clinic Location (if known)

Specialty Area to be Referred

Or, let the Gillette One Call Access Referral Nurse determine the appropriate specialty.
❒ Yes

Specific Name of the Provider I Would Like to Refer to

Continued on back.

*This information is required to complete a referral.

Patient Information (continued)

Reason for Referral:*

Diagnosis/Symptoms:*

Additional Medical History Information:

Additional Documents:
Our specialists have requested documentation to assist us in the care of your patient. Please fax the following documents to medical records at 651-325-2137.

- Patient face sheet.*
- Clinic notes, including diagnoses or problem lists.
- Relevant family history.
- Relevant test (lab or imaging) results.
- Current medication list and allergies.
- Current care management plans or recent referrals for therapies, medical equipment, etc.
- Diagnosis of mental health condition, substance abuse or behaviors affecting health.

*This information is required to complete a referral.