CHOC Children's Specialists

Division of Hematology Referral Request

Division Phone: 714.509.8459 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Hematology.

- If a Pediatric *Oncology* consultation is requested, please do not use this form, call 714.509.4348.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance : _____ Parent Cell: _____

1. Is this an **emergent** hematology referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD /NP/RN with clinical information to 714.509.8459**

2. Please describe the patient's chief complaint and include onset and laboratory results:

_____

_____

3. What is the key question you want us to answer?_____

_____

_____

4. Please select one of the following clinics:

☐ **General Hematology**	Includes but not limited to: Anemia, Thrombocytopenia, Neutropenia, Bleeding disorders
☐ **Immune Deficiency**	Includes but not limited to: Recurrent infections, Di George Syndrome, Hypogammaglobulinemia, Chronic Granulomatous Disease
☐ **Hemangioma**	Includes but not limited to: Hemangioma, Venous malformation, Vascular malformation, Lymphatic malformation, Port wine stain, Birth marks
☐ **Thrombosis Clinic**	Includes but not limited to: Thrombosis, Thrombophilia, and Thrombosis Prophylaxis, Anticoagulation

To expedite appointment scheduling, please provide the following by FAX to 855-246-2329:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Prior hematology records including lab results and a growth chart**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____