Pediatric Development and Rehabilitation

RANDALL CHILDREN'S HOSPITAL
LEGACY EMANUEL

Multi-disciplinary Clinics Referral Form

Patient information

Name _____

DOB *(mm/dd/yyyy)* _____

MR number _____

Randall Children's Hospital at Legacy Emanuel
2801 N. Gantenbein Ave., Room 2225
Portland, OR 97227
Phone: **503-413-4505**
Fax: **503-413-4719**

☐ Legacy Emanuel tax ID: 93-0386823

Insurance _____ I.D. number _____

Guarantor _____ Guarantor DOB *(mm/dd/yyyy)* _____

Primary care provider _____ Phone _____ Fax _____

Referral coordinator: Please submit referral to insurance company, if necessary, for number of visits indicated.

Clinic appointment	Due (month/year)	Provider	Appointment date and time
☐ **Feeding disorders clinic** One physician visit (99205-new/99215-established) One clinic visit (97167-OT/92610-SLP/97802-RD)			
☐ **Craniofacial disorders clinic** One physician visit (99205-new) One clinic visit (97163-PT/96110-SP) One neuropsychology test (96150 x2)			
☐ **Cerebral palsy clinic** Two physician visits (99205-new) One clinic visit (97163-PT)			
☐ **Autism spectrum disorder clinic** One physician visit (99205-new) One clinic visit (97167-OT and 92523-SLP) One conference (99366 and 99368) Five neuropsychology tests (96101)			
☐ **NICU follow-up clinic** One physician visit (99205-new) One clinic visit (97167-OT or 97163-PT)			
☐ **Wheelchair seating clinic** One physician visit (99205-new) One clinic visit (97163-PT/97167-OT) (Initiate wheelchair seating pre-clinic worksheet)			
☐ **Developmental pediatric assessment** One physician visit (99205-new) Developmental testing (99116 and 96111)			

Referral must include current chart notes and patient demographic information.

Authorization number _____ Number of visits _____ Date range _____

ICD-10 code(s) _____

Physician/PCP signature _____ Date _____ Time _____