

Please visit the CHaD web site for specialty provider office locations at www.chadkids.org

Please select the service requested:

- Consultation, test & treat Known dx – assume subset of care Test only

Please select the specialty(s) requested:

Lebanon: Phone (866) 346-2362 Fax (603) 676-4080				
<input type="checkbox"/> Adolescent Medicine	<input type="checkbox"/> Endocrinology*	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Spasticity
<input type="checkbox"/> Allergy & Clinical Immunology	<input type="checkbox"/> Gastroenterology*	<input type="checkbox"/> Lipid & Weight Mgmt**	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Sports Medicine
<input type="checkbox"/> Cardiology (Pediatric, Fetal, Adult Congenital)	<input type="checkbox"/> General Surgery	<input type="checkbox"/> Neonatology	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> CAPP (Child Advocacy & Protection Program)	<input type="checkbox"/> Genetics	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Urology
<input type="checkbox"/> Child Development	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Neurology***	<input type="checkbox"/> Pulmonology	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Hematology/Oncology	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Rheumatology	

Manchester (1st Floor): Phone (603) 695-2745 Fax (603) 629-1869				
<input type="checkbox"/> Cardiology (Pediatric, Fetal, Adult Congenital)	<input type="checkbox"/> Medical Genetics [Phone: (603) 629-8355 Fax: (603) 676-4080]	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Urology	
<input type="checkbox"/> General Surgery	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Sports Medicine		

Manchester (2nd Floor): Phone (603) 695-2790 Fax (603) 629-1785				
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Gastroenterology*	<input type="checkbox"/> Neonatology		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Infectious Disease/HIV Clinic	<input type="checkbox"/> Nutrition		
<input type="checkbox"/> Endocrinology*	<input type="checkbox"/> Lipid & Weight Management*	<input type="checkbox"/> Pulmonology		

Bedford:				
<input type="checkbox"/> Allergy [Phone: (603) 695-2560 Fax: (603) 629-8345] <input type="checkbox"/> Infectious Disease [Phone: (603) 650-6063 Fax: (603) 650-6110]				

Nashua:				
<input type="checkbox"/> Gastroenterology [Phone: (603) 695-2745 Fax: (603) 629-1785] <input type="checkbox"/> Medical Genetics [Phone: (603) 629-8355 Fax: (603) 676-4080]				

Dover (CHaD @ Wentworth-Douglass Hospital):		Phone (603) 740-2366 Fax (603) 740-2536		
<input type="checkbox"/> Cardiology (Pediatric, Fetal, Adult Congenital)	<input type="checkbox"/> Endocrinology*	<input type="checkbox"/> Gastroenterology*	<input type="checkbox"/> Nephrology	

Exeter:	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Gastroenterology
Phone: (603) 695-2740 Fax (603) 629-1869	Phone: (603) 695-2790 Fax: (603) 629-1785	

* Growth chart needed w/ referral

**Growth chart, all past labs & last pertinent note REQUIRED with each referral

***For Manchester Pediatric Neurology appointments, please use Pediatric & Adult Neurology Manchester referral form at www.chadkids.org

All highlighted items must be completed

Today's Date: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Patient's Name: Last _____	First _____	MI: _____	DOB: _____	
Address: _____		Home #: _____	Cell #: _____	
Name of Policy Holder: _____	DOB of Policy Holder: _____	Language assistance needed: <input type="checkbox"/> Patient <input type="checkbox"/> Parent/Guardian Specify language: _____		
Reason for Referral/Diagnosis: _____				
Urgency of Appointment: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent Specialist Preferred/Requested (Optional): _____				
Referring Provider: _____		Office Phone: _____	Office Fax: _____	
Address: _____				
Primary Care Provider (if different from above): _____		Office Phone: _____	Office Fax: _____	
Insurance: _____		Policy #: _____	Subscriber # _____	
Insurance Address: _____		Group #: _____	:	

Please attach relevant office records and/or prior lab studies/images with this form.

FOR CHaD USE ONLY

Received by: _____

Patient MRN: _____

Reminder in system & sent to review

New Patient Established Patient Date last seen (if applicable): _____ By: _____

Appointment Information: Date: _____ Provider: _____ Duration: _____

Date Intake Reviewed: _____ Reviewed By: _____ Studies: _____

OK as scheduled Change schedule as follows/comments: _____