CHaD Pediatric Specialties

Consultation and Appointment Request Form

Dartmouth-Hitchcock CHILDREN'S HOSPITAL AT DARTMOUTH

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

☐ Adolescent Medicine	☐ Endocrinology*	☐ Infectious Disease	☐ Ophthalmology	☐ Spasticity
☐ Allergy & Clinical Immunology	☐ Gastroenterology*	☐ Lipid & Weight Mgmt**	☐ Orthopedics	☐ Sports Medicine
☐ Cardiology (Pediatric, Fetal, Adult Congenital)	☐ General Surgery	☐ Neonatology	☐ Otolaryngology	☐ Thoracic Surgery
☐ CAPP (Child Advocacy & Protection Program)	☐ Genetics	☐ Nephrology	☐ Plastic Surgery	☐ Urology
☐ Child Development	☐ Gynecology	☐ Neurology***	☐ Pulmonology	
☐ Dermatology	☐ Hematology/Oncology	☐ Neurosurgery	☐ Rheumatology	

Manchester (1st Floor): Phone (603) 695-2745 Fax (603) 629-1869

☐ Cardiology (Pediatric, Fetal, Adult Congenital) ☐ Medical Genetics [Phone: (603) 629-8355 Fax: (603) 676-4080] ☐ Osteoporosis ☐ Urology
☐ General Surgery ☐ Nephrology ☐ Pulmonology ☐ Neonatology ☐ Sports Medicine

Manchester (2nd Floor): Phone (603)695-2790 Fax (603) 629-1785

☐ Cystic Fibrosis ☐ Gastroenterology*
☐ Diabetes ☐ Infectious Disease/HIV Clinic ☐ Nutrition
☐ Endocrinology* ☐ Lipid & Weight Management*

Bedford:

☐ Allergy [Phone: (603) 695-2560 Fax: (603) 629-8345] ☐ Infectious Disease [Phone: (603) 650-6063 Fax: (603) 650-6110]

Nashua:

☐ Cardiology [Phone: (603) 695-2740 Fax: (603) 629-1869] ☐Medical Genetics [Phone: (603) 629-8355 Fax: (603) 676-4080]

Dover (CHaD @ Wentworth-Douglass Hospital): Phone (603) 740-2366 Fax (603) 740-2536

☐ Cardiology (Pediatric, Fetal, Adult Congenital) ☐ Endocrinology* ☐ Gastroenterology* ☐ Nephrology ☐ **Pulmonology**

Exeter: ☐ Cardiology **Phone: (603) 695-2740 Fax (603) 629-1869** ☐ Gastroenterology **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: ☐ Male ☐ Female			
Patient's Name: Last	First	**MI:**	**DOB:**
Address:	**Home #:**	**Cell #:**	
Name of Policy Holder:	**DOB of Policy Holder:**	Language assistance needed: ☐ Patient ☐ Parent/Guardian	Specify language:
Reason for Referral/Diagnosis:			
Urgency of Appointment: ☐ Routine ☐ 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

Patient MRN: _____

Received by: _____ ☐ 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: _____