Children's Hospital at Dartmouth-Hitchcock

CHaD Pediatric Specialties

Consultation and Appointment Request

Please select the service requested: ❒ Consultation, test and treat ❒ Known dx – assume subset and care ❒ Test only

Please select the specialty requested:

Lebanon: Phone: (866) 346-2362 Fax: (603) 676-4080 Medically Urgent Fax: (603) 640-1909

- ❒ Adolescent Medicine
- ❒ Allergy & Clinical Immunology
- ❒ Cardiology (Pedi Cardiology, Adult Congenital & Fetal Echocardiogram)
- ❒ CAPP (Child Advocacy & Protection Program)
- ❒ Child Development
- ❒ Dermatology
- ❒ Endocrinology*
- ❒ Gastroenterology*
- ❒ General Surgery
- ❒ Genetics
- ❒ Hematology/Oncology
- ❒ Infectious Disease
- ❒ Lipid & Weight Management*
- ❒ Neonatology
- ❒ Nephrology
- ❒ Neurology***
- ❒ Neurosurgery
- ❒ Ophthalmology
- ❒ Orthopaedics
- ❒ Otolaryngology
- ❒ Plastic Surgery
- ❒ Pulmonology
- ❒ Rheumatology
- ❒ Sports Medicine
- ❒ Thoracic Surgery
- ❒ Urology

Manchester-1st floor: Phone: (603) 695-2745 Fax: (603) 727-7980

- ❒ Cardiology (Pedi, Fetal, Adult Congenital)
- ❒ General Surgery
- ❒ Medical Genetics: Phone: (603) 629-8355 Fax: (603) 676-4080
- ❒ Neonatology
- ❒ Nephrology
- ❒ Pulmonology
- ❒ Urology
- ❒ Sports Medicine

Manchester-2nd floor: Phone: (603) 695-2790 Fax: (603) 727-7981

- ❒ Cystic Fibrosis
- ❒ Diabetes
- ❒ Endocrinology*
- ❒ Gastroenterology*
- ❒ Infectious Disease
- ❒ Lipid & Weight Management*
- ❒ Nutrition

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 (Pedi, Fetal, Adult Congenital)
- ❒ Endocrinology*
- ❒ Gastroenterology
- ❒ Nephrology
- ❒ Pulmonology

*Growth chart needed with referral **Growth chart, all past labs and last pertinent notes are **required** with referral

***For Manchester Pediatric Neurology appointments, please use the Pediatric & Adult Neurology Manchester form from chadkids.org

ALL HIGHLIGHTED ITEMS MUST BE COMPLETED Today's Date: _____

❒ Male ❒ Female DOB: _____

Patient's Name: Last: _____ First: _____ MI: _____

Address: _____ Home Phone: _____ Cell Phone: _____

Language assistance needed: ❒ Patient ❒ Parent/Guardian Specify language: _____

Reason for Referral/Diagnosis: _____

Urgency of Appointment: ❒ Routine ❒ Urgent Explain: _____

Specialist Preferred/Requested (optional): _____

Referring Provider: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Address: _____

Primary Care Provider (if different from above): _____ Office Phone: _____ Office Fax: _____

Insurance: _____ Policy#: _____ Group#: _____

Insurance Address: _____ Subscriber#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

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

FOR CHaD USE ONLY Patient MRN: _____ ❒ Reminder in system & sent to review

Received by: _____ ❒ 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: _____ 20190618