

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

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

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

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|---|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Cardiology (Pedi, Fetal, Adult Congenital) | <input type="checkbox"/> Neonatology | <input type="checkbox"/> Pulmonology | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Urology | |
| <input type="checkbox"/> Medical Genetics Phone (603) 629-8355 Fax (603) 676-4080 | | | |

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

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|--|--|---|------------------------------------|
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Endocrinology* | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastroenterology* | <input type="checkbox"/> Lipid & Weight Management* | |

Bedford:

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

- | | |
|--|---|
| <input type="checkbox"/> Cardiology [Phone: (603) 695-2740 Fax: (603) 629-1869 | <input type="checkbox"/> Medical Genetics Phone (603) 629-8355 Fax (603) 676-4080 |
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Dover (CHaD @ Wentworth-Douglass Hospital): Phone (603) 740-2366 Fax: (603) 740-2536

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|---|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cardiology (Pedi, Fetal, Adult Congenital) | <input type="checkbox"/> Endocrinology* | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Pulmonology |
| | <input type="checkbox"/> Gastroenterology | | |

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| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Gastroenterology |
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*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: _____ 20171109