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

Urgency of Appointment: ❒ Routine ❒ Urgent Explain: ______

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

Concord and Keene: ❒ Cardiology: Phone: (603) 653-9888 Fax: (603) 676-4080 ❒ check for Concord ❒ check for Keene

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: ______

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: ______ Subsciber#: ______

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: ______

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