Nemours Children's Specialty Care

Appointment Request Fax

TO: **Nemours Appointment Scheduler**

FAX NUMBER: (850) 473-4543

PHONE NUMBER: (850) 505-4700

DATE:

FROM: _____

FAX NUMBER: _____

PHONE NUMBER: _____

TOTAL NUMBER OF PAGES INCLUDING COVER: _____

Please check which specialty you would like your patient to see:

- ❑ **Allergy**
  p (850) 505-4730
- ❑ **Cardiology**
  p (850) 505-4775
- ❑ **ENT**
  p (850) 505-4735
- ❑ **Endocrinology**
  p (850) 505-4745
- ❑ **Gastroenterology**
  p (850) 505-4760
- ❑ **Nephrology**
  p (850) 505-4750
- ❑ **Neurosurgery**
  p (850) 505-4720
- ❑ **Orthopedics**
  p (850) 505-4720
- ❑ **Pulmonology/ Sleep Center**
  p (850) 505-4785
- ❑ **Rheumatology**
  p (850) 505-4730
- ❑ **Urology**
  p (850) 505-4731

Please check which location you would prefer your patient to visit:

❑ Nemours Children's Specialty Care, Pensacola

❑ Nemours Children's Specialty Care, Bonifay

❑ Nemours Children's Specialty Care, Ft. Walton Beach

In compliance with Centers for Medicare and Medicaid Services guidelines (CMS Transmittal 788), please complete this section and return the form via fax to (850) 473-4543:

Patient's Name: _____ DOB: _____ Gender: M or F

Requesting Physician: _____

Reason for Visit (Diagnosis/Symptoms): _____

Specialty Requested (and Provider, if Preference): _____

Please indicate if this request is for:

❑ A consultation (opinion or advice)

❑ Transfer of care for a specific problem

❑ Other _____

PLEASE FAX ALL PERTINENT MEDICAL RECORDS INCLUDING X-RAYS, LABS AND TEST RESULTS.

Parent's or Legal Guardian's Name: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Insurance Name: _____ Policy Holder Name: _____

ID or Policy Number: _____ Group Number: _____ # of Visits: _____

Authorization Number _____ Effective Date: _____ Expiration Date: _____