

# Yale Pediatric Thyroid Center A PRACTICE OF THE YALE MEDICAL GROUP

NEW PATIENT FORM

Date: \_\_\_\_\_

**If calling to schedule an appointment (203-737-5971; fax 203-737-5972), we will fax form to you for confirmation.**

1  **PHONE OPTION/APPOINTMENT CONFIRMATION:** Your patient has an appointment scheduled with \_\_\_\_\_ from the \_\_\_\_\_ service on \_\_\_\_\_ at \_\_\_\_\_ AM/PM. Please provide a brief medical history and current medications **then fax this form to the appropriate number listed below ALONG WITH PERTINENT MEDICAL RECORDS.**

SELF REFERRED       PROVIDER REFERRED

2  **FAX OPTION/APPOINTMENT REFERRAL:** Please complete this form in its entirety and fax it to the number listed below ALONG WITH PERTINENT MEDICAL RECORDS.

Thyroid Center 203-737-5972

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Phone: (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_ (Cell) \_\_\_\_\_

Primary Language if other than English: \_\_\_\_\_ Interpreter Req:  Yes  No

Insurance Company Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Medical History/Reason For Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospital Discharge:  Yes  No If YES, Specialty Consulted In Hospital:  Yes  No  
Medications: \_\_\_\_\_

**Labs/Diagnostic Imaging/Records (Please indicate below records you are faxing with this form)**

<input type="checkbox"/> Bloodwork	<input type="checkbox"/> Cardiac Tests
<input type="checkbox"/> Stool/Urine	<input type="checkbox"/> Neurologic Testing
<input type="checkbox"/> Pertinent Office Records/Growth Charts	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> X-ray/other diagnostic imaging	<input type="checkbox"/> Other (specify): _____

PCP/Referring Provider Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail(optional): \_\_\_\_\_

**For Yale Office Use Only**

Appt. faxed back to PCP: Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Info. sent to parent/guardian: Date: \_\_\_\_\_ Initials: \_\_\_\_\_

**(To Be Completed For Fax Option Appointment Referrals Only)**

Date Received: \_\_\_\_\_ Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Scheduled Provider: \_\_\_\_\_ Authorized By: \_\_\_\_\_

Parent/Guardian Notified:  Yes  No Conversation: \_\_\_\_\_ Message: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_