University of Illinois
College of Medicine at Peoria

Specialty Request Form

OSF HealthCare
Children's Hospital of Illinois

☐ Consult/Initiate Treatment ☐ Treatment Only ☐ Consult Only
(Consult = request for opinion/advise on diagnosing or treating)

Fax (309) 624-7778
- ☐ Adolescent Medicine
- ☐ Peds Gynecology
- ☐ Infectious Disease

Fax (309) 308-2009
- ☐ Allergy

Fax (309) 308-3935
- ☐ Cadiovascular Surgery
- ☐ Congenital Diaphragmatic Hernia
- ☐ Congenital Heart (Peoria)
- ☐ ENT
- ☐ General Surgery
- ☐ Orthopedics
- ☐ Spina Bifida
- ☐ Urology

Fax (815) 227-9242
- ☐ Congenital Heart (Rockford)

Fax (309) 655-4154
- ☐ Cystic Fibrosis
- ☐ Home Vent Clinic
- ☐ Pulmonology
- ☐ Sleep Medicine

Fax (309) 624-2481
- ☐ Diabetic Resource Center (New Type 1 diagnosis call 309-624-2480)

Fax (309) 681-6965
- ☐ Developmental Pediatrics
- ☐ Psychiatry

Fax (309) 655-7392
- ☐ Eating Disorders

Fax (309) 624-9694
- ☐ Peds Resource Center

Fax (309) 624-9524
- ☐ Genetics

Fax (309) 623-4365
- ☐ Ophthalmology

Fax (309) 624-8884
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Nephrology
- ☐ Neurology
- ☐ Obesity/Weight Mgmt.
- ☐ Palliative Care

Fax (309) 624-9733
- ☐ Neuropsychology
- ☐ Resource Link

Fax (309) 676-5920
- ☐ Neurosurgery

Fax (309) 655-6472
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy

Fax (309) 691-9757
- ☐ Psychotherapy

Fax (309) 624-9848
- ☐ St. Jude Clinic Hematology/Oncology

Specialist Preferred/Requested:_____ **Time frame to be seen:**_____

Reason for Request (symptom(s) to be evaluated / condition(s) requesting feedback / treatment:

_____

_____

Patient Information:

First Name:_____ Last Name:_____ MI:_____

DOB:_____ Sex: ☐ M ☐ F Social Security Number:_____

Address:_____ Phone Number:_____

City:_____ State:_____ Zip Code:_____

Translator Needed: ☐ Yes ☐ No If yes, Language Needed:_____

Parent/Legal Guardian Information

Mother's Name:_____ Last Name:_____

Father's Name:_____ Last Name:_____

Other Relationship:_____ First Name:_____ Last Name:_____

Address (*if different*):_____

City:_____ State:_____ Zip Code:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____ Pager Phone: (_____)_____

Guarantor Information:

First Name:_____ Last Name:_____ MI:_____

DOB:_____ Sex: ☐ M ☐ F Social Security Number:_____

Requesting Provider:_____ NPI:_____

Collaborating Physician for Mid Level Providers:_____

Office Contact Person:_____

Office Phone Number: (_____)_____ Office Fax Number: (_____)_____

Pre-Auth Required: ☐ Yes ☐ No Auth No.:_____ No. of visits authorized:_____

Please send the following information with referral:

- ☐ Patient Face Sheet
- ☐ Copy of insurance card/self-pay (legible, front & back)
- ☐ Referral/Order generated by EMR
- ☐ Office visit notes pertinent to condition(s)/symptom(s)
- ☐ All imaging related to condition(s)/symptom(s)
- ☐ All lab results to condition(s)/symptom(s)
- ☐ List of current medication (including OTC & Herbals)
- ☐ List of allergies

Requesting Provider's Signature:_____

SPECIALIST OFFICE USE ONLY

Appointment Information: Appointment scheduled: ☐ Yes ☐ No Information sent to family: ☐ Yes ☐ No

Date:_____ Time:_____ Location:_____

Appointment with Dr.:_____