UNC SCHOOL OF MEDICINE

University of North Carolina
Department of Surgery

CLINIC REFERRAL FORM

Today's Date: _____

CLINIC DIVISION OF UNC DEPARTMENT OF SURGERY

To refer a patient to the following division, please fax this form to the number below:

Pediatric Plastic & Reconstructive Surgery

Fax: 919-966-3814 / Phone: 919-843-1087

● ● ● REASON FOR REFERRAL ● ● ●

Diagnosis/ICD-9 Codes:

_____

Name of Requested Clinician: ___ John A. van Aalst, MD
(if applicable) ___ Other _____

Onset Date of
Signs and Symptoms ____/____/ ____

Reason for Referral: ☐ Consultation and Recommendations, then return to referring provider for care ☐ Transfer of Care for this problem ☐ 2nd Opinion

Clinical Documentation: *(Required to proceed with scheduling an appointment)*

Patient Records, Labs, and Radiological Reports have been: ☐ Faxed ☐ Mailed Date Sent: _____

Is this a joint case (to be coordinated with another surgical specialty)? ☐ Yes ☐ No If yes, which specialty:_____

● ● ● REFERRAL SOURCE INFORMATION ● ● ●

Referring Provider Name: _____

Provider #: *(For Internal Providers)* _____

Pager #: *(For Internal Providers)* _____

Address: _____

Phone #: _____

Fax#: _____

● ● ● PATIENT INFORMATION ● ● ●

***ALL PATIENTS NEW TO UNC MUST CALL 919-843-3377** to establish a UNC Medical Record Number*

**For patients already in the UNC system, please update any changes below. If no changes, please continue to the Insurance section.*

UNC Medical Record #: _____

Last Name: _____ First Name: _____ Middle: _____

Parent/Guardian Name, if patient is under 18 years: _____

Interpreter Needed? ☐ Yes ☐ No If yes, language: ☐ Spanish ☐ Other _____

Sex: ☐ M ☐ F DOB: ____/____/ ____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Daytime Phone #: _____ Alternate Phone #: _____

● ● ● INSURANCE INFORMATION ● ● ●

Insurance Name: (note if no insurance coverage)

_____

Authorization Required: ☐ Yes ☐ No

Authorization #: _____ # of visits: _____

Effective Dates: _____

● ● ● CONFIRMATION OF SCHEDULED APPOINTMENT ● ● ●

(Once appointment has been schedule by staff, the following information will be completed and faxed back)

Appt Date: _____ **Appt Time:** _____ **Provider Name:** _____