

Referral to a Pediatric Specialist

To: _____ Fax: _____

From: _____

Name of patient: _____ Gender: _____ Date of birth: _____

Name of parent/guardian: _____ Parent/guardian phone number: _____

Name of referring physician: _____

Insurance: _____ Insurance ID #: _____

Reason for referral: _____

Referral class: ☐ Urgent ☐ Routine

Please fax all relevant chart notes, diagnostic test results, demographics and referral authorization (if required).

☐ **Audiology**

First Hill, Ballard, Issaquah,
Cherry Hill
T: 206-215-HEAR(4327)
F: 206-215-1771

☐ **Endocrinology**

(Metabolic Program only)
T: 206-215-2700
F: 206-215-2702

☐ **Gastroenterology**

T: 206-215-2700
F: 206-215-2702

☐ **General Surgery**

T: 206-215-2700
F: 206-215-2702

☐ **Infectious Disease**

T: 206-215-2700
F: 206-215-2702

☐ **Nephrology**

T: 206-215-2700
F: 206-215-2702

☐ **Neurology & Epilepsy**

T: 206-215-1440
F: 206-215-1441

☐ **Nutrition**

T: 206-215-2700
F: 206-215-2702

☐ **Orthopedics**

T: 206-215-2700
F: 206-215-2702

☐ **Otolaryngology**

T: 206-215-1770
F: 206-215-1771

☐ **Pulmonology**

T: 206-215-2700
F: 206-215-2702

☐ **Sleep Medicine**

T: 206-386-4744
F: 206-215-1135

☐ **Therapy**

(Physical, Occupational, Speech)
T: 206-386-3592
F: 206-386-6657

☐ **Urology**

T: 206-215-2700
F: 206-215-2702

We do not discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity or expression, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (TTY: 711)
注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 888-311-9127 (TTY: 711)