Providence
SWEDISH

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