Children's Cancer and Blood Disorders Referral Form

Please call Pediatric Scheduling at: 843-876-0444 to provide demographics and insurance information
THEN fax this form along with any other referrals documents to: 843-985-4255

Referring Physician: _____ **Office Name:** _____
Office Phone Number: _____

Patient's Name: _____ **Date of Birth:** _____
Parent's Name: _____ **Phone Numbers:** _____

PLEASE NOTE: Faxing a referral without contacting Children's Services at the above number or sending all pertinent documentation will result in a delay in scheduling the appointment.

1. **Has this patient been seen at MUSC's Cancer and Blood Disorders Clinic in the past?**
   ☐ Yes (please comment in section 5 reason for re-referral)
   ☐ No
2. **Urgent Referral (Please call us, Monday-Friday at 843-985-1663 to discuss patient with an MD)**
3. **Reason for Referral (Check all that apply):**
   ☐ Cancer diagnosis or concern
   ☐ Anemia
   ☐ Bleeding/clotting disorder
   ☐ Abnormal newborn screen
   ☐ Abnormal labs
   ☐ Previous history of cancer that requires follow up
   ☐ Other: _____
4. **Please include the following information with your referral:**
   - Insurance information (Name of Policy, Group Number, Subscriber)
   - Demographic information, including contact phone numbers
   - Medication list
   - Clinic notes
   - Pertinent labs
   - Newborn screening if applicable
5. **Summary of your concern leading to this referral:**

   _____
   _____
   _____
   _____

** Please note our new **econsult** option via Epic/Carelink, if you simply have a questions for one of our providers and/or would like a patient's chart reviewed**