Clinic *for* Special Children®

New Patient Referral Form

Please complete this form and fax it along with all pertinent medical records (progress notes, lab results, genetic testing, imaging studies, etc.) to (717) 687-9237. If you have questions, please call us at 717-687-9407. Thank you!

Referral Date: _____

Referring Provider: _____ Specialty: _____

Referring Provider Phone #: _____ Fax #: _____

Is the patient currently admitted? If so, which hospital system? _____

Patient's Name: _____ Date of Birth: ____/_____/_____

SSN: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____

Mother's Name: _____ Mother's DOB: ____/_____/_____ Mother's SSN: _____

Father's Name: _____ Father's DOB: ____/_____/_____ Father's SSN: _____

Does the patient have insurance? Y/ N If so, name of Primary Insurance: _____

CSC is self-pay, but keeps insurance on file

Reasons for Referral (check all that apply):

☐ Birth defects ☐ Failure to thrive ☐ Developmental delays ☐ Seizures

☐ Metabolic disease _____ ☐ Dysmorphic features _____

☐ Genetic condition suspected: _____

☐ Other: _____

Services Requested (check all that apply):

☐ Genetic consultation: ☐ Establish primary care/management: ☐ Establish specialist care:_____

☐ Second opinion: _____

Has patient had previous genetic testing? Y/ N

Results of genetic workup:

Note: Any prior genetic testing results must be included in the referral.

Street Address | 20 Community Lane, Gordonville, PA 17529
Mailing Address | P.O. Box 500, Intercourse, PA 17534
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