Children's MINNESOTA

The Kid Experts®

Children's Minnesota Referral Form

Please complete this form and fax this along with the requested patient medical records noted below. Specific clinic numbers can be found at **childrensMN.org/referral**

Date of request: _____

☐ **Routine**

☐ **Urgent referral**

Referring provider information

Clinic name: _____ Clinic fax #: _____

Name of referring provider: _____

Best contact name and # if additional information is needed: _____

Reason for referral (clinical question you would like answered, please give as much information as possible):

_____

_____

_____

Patient information **(Complete only if face sheet not included.)**

Patient name: _____ DOB: _____

Parent or legal guardian name: _____

Address: _____

Phone: _____

***** We request the following information for this referral-prior to scheduling the appointment. *****

☐ Last office visit (Referring provider and Primary Care)
☐ Labs — last 6 months
☐ Images — last 6 months
☐ Growth Charts

☐ Language: _____ Interpreter needed? ☐ Yes ☐ No

Please include any additional information that may help with triage:

_____

_____

_____

Thank you for your time!

For immediate assistance please call the clinic numbers listed for the specialty you are looking to refer to.
Directory listing at **childrensMN.org/referral**

RESET FORM