**Pediatric Hematology**

University of Iowa Stead Family Department of Pediatrics

Division of Pediatric Hematology/Oncology

200 Hawkins Drive

Iowa City, IA 52242

**New Patient Referral Form**

**Date of Request:** \_\_\_\_\_\_\_\_\_\_\_\_

**Please complete this form and fax this along with the requested patient medical records noted below to our Pediatric Hematology Nursing Triage:**

**FAX: 319-356-7659**

PH: 319-356-8223

If your patient needs to be seen **emergently (within 1-3 days)**, please call 319-356-1616 and ask to speak to the Pediatric Hematologist on call to discuss your concerns and facilitate an urgent visit. If you feel your patient needs to be seen **urgently (within 1-2 weeks)** please call 319-356-8223 to facilitate an urgent visit.

Non-Urgent referrals may be scheduled in greater than 8 weeks. Bleeding disorder and Sickle Cell consults must be seen initially at the SFCH Children’s Hospital in Iowa City. There are two outreach clinic locations that may be appropriate for your patient, if desired please chose below:

\_\_\_ Bettendorf \_\_\_ Cedar Falls

**Reason for Referral:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*\*\* We request the following information for this referral \*\*\***

\_\_\_\_ Face sheet with patient demographics, including insurance information

\_\_\_\_ Most recent clinic note, including growth chart

\_\_\_\_ Most recent H&P/discharge summary if hospitalized and any ED visit notes related to referral

\_\_\_\_ Lab results from: 1) onset of issue 2) within last 6 months

\_\_\_\_ Other services consulted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Please notify us of the details of any prior communication with Pediatric Hematology (who, when, and guidance considered) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Any additional information that may help with triage and visit planning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Additional information or bleeding disorder referrals**

(elevated PT/PTT, Hemophilia, von Willebrand Disease, heavy menses, etc)

\_\_\_\_ Please provide personal bleeding history and any known family history of bleeding disorders/bleeding symptoms

\_\_\_\_ Upcoming surgeries or procedures patient need or are scheduled