Clear Form

PORTOFINO PEDIATRICS
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PATIENT REFERRAL FORM

SPECIALTY DEPARTMENT: Emergency Room **DATE :** _____/_____/_____

(Contact information attached)

MEDICAL INFORMATION

T _____ HR _____ RR _____ BP _____

WT _____ kg WT _____% BMI _____%

HT _____cm _____% HC _____cm _____%

Immunization status UTD ☐ Y / ☐ N
Last TdaP _____/_____/_____
Last menses _____/_____/_____
Last meal _____/_____/_____

Allergies _____

Meds _____

_____

Reason for referral _____

_____

_____

_____

Brief history/Work up_____

_____

_____

_____

Meds / Treatment given (specify time)_____

_____

Initials (MA) _____

PATIENT INFORMATION

Patient's Name _____

DOB _____/_____/_____ Gender ☐Female ☐Male

Patient/Guardian Name _____

Relationship _____

Phone _____

INSURANCE INFORMATION

Health Plan _____

Authorization# _____

DIAGNOSIS _____

_____

AUTHORIZATION TO EVALUATE AND TREAT

Referring _____ MD/DO

Signature _____

Group NPI # 1194944611_____

Referring _____ ARNP/PA-C

Signature _____

ATTACHMENTS

☐Medical Record Notes
☐Growth Curves
☐Pertinent Operative Note
☐Results of Diagnostic/Imaging Studies
☐Pertinent Lab Studies
☐Emergency Room/Inpatient Notes

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EMERGENCY ROOM/HOSPITALS

Homestead Hospital
975 Baptist Way
Homestead, FL 33033
(786)243-8000

Baptist Hospital
8900 N Kendall Dr
Miami, FL 33176
(786)596-1960

Jackson Memorial Hospital
Holtz Children's Hospital
1611 NW 12th Ave
Miami FL 33136
305-585-5437

Jackson South Community Hospital
9333 SW 152 Street
Miami, FL 33157
Phone: 305-251-2500

Nicklaus Children's Hospital
3100 SW 62 Ave
Miami, FL 33155
(305)666-6511

Nicklaus Children's, Palmetto Bay
17615 SW 97 Ave, Franjo Road
Palmetto Bay, FL 33157
(786)268-1777