

Orthopedics - Request for Service Order

Pt. Name: _____

DOB: _____

MRN (If available): _____

Parent Name _____

Phone # _____ Preferred time: 8-12, 12-5, after 5

Insurance: Medicaid, PPO, HMO, Self-pay / Other

Referring Provider Name: _____

Practice Name: _____

Date of Request: _____

Please attach patient's demographics

Step 1: When should patient be seen?

- ASAP (\leq 24 hours)
- For physicians new to Lurie Children's – Call the KidsDoc VIP Line – **(800) 540-4131, Option 4**
 - For all other physicians, call the Lurie Children's Orthopedics Division Directly at **(312) 227-6190**
- Within 2 weeks
- > 2 weeks

Note: Chief Complaints marked with * are expected to be referred ASAP (\leq 24 hours)

Step 2: Identify Chief Complaint

- | | | |
|--|--|--|
| <input type="checkbox"/> Fracture / Injuries

<input type="checkbox"/> Back Pain

<input type="checkbox"/> Cerebral Palsy

<input type="checkbox"/> Concussion

<input type="checkbox"/> Foot Deformity
<input type="checkbox"/> Infant <input type="checkbox"/> Child & Adolescent
<input type="checkbox"/> Gait disturbance

<input type="checkbox"/> Hand Deformity | <input type="checkbox"/> Hip
<input type="checkbox"/> Infant <input type="checkbox"/> Child & Adolescent

<input type="checkbox"/> In-toeing

<input type="checkbox"/> Joint Pain
Sports Related? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Shoulder
<input type="checkbox"/> Elbow
<input type="checkbox"/> Wrist
<input type="checkbox"/> Hip
<input type="checkbox"/> Knee
<input type="checkbox"/> Ankle | <input type="checkbox"/> Leg length discrepancy

<input type="checkbox"/> Mass
Location _____

<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Slipped capital femoral epiphysis (SCFE) *

<input type="checkbox"/> Spina Bifida

<input type="checkbox"/> Other _____ |
|--|--|--|

Step 3: Info Requested for Each Referral

- 1) How long has the patient had the condition? _____ (days/weeks/months/years)
- 2) Pertinent and Quick Patient History (1 – 2 sentences):

- 3) Questions referring provider wants answered by Specialist

- 4) Has the referring provider already spoken with a Lurie specialist about this referral?

- 5) Is there a preferred provider to see the patient?

- 6) Which location is preferred for the patient's appointment?

Ensure the following are sent to the Specialist (Orthopedics Fax #312.227.9404)

- | | |
|---|-------------------|
| 1. Imaging and X-Rays (provide disk if available) | 3. Pertinent Labs |
| 2. Current Medications | |

Please submit this request along with records to KidsDoc Fax #: 312.227.9832