Ann & Robert H. Lurie
Children's Hospital of Chicago®

Request for consultation

Please fax to 312.227.9832

Patient information *(please print)*

Date referred _____ Patient birth date_____ Sex _____

Patient name _____

Patient address_____

City _____ State _____ Zip _____

Parent name_____

Home phone number_____ Cell phone number _____

Insurance carrier _____

To view a list of all insurance plans that cover a specific doctor, please refer to the "Find a doctor" section of our website, luriechildrens.org/FAD.

Language spoken _____

Specialty requested _____

Reason for consultation

History/Symptoms/Potential diagnosis/Special needs _____

_____

_____

_____

Is this a second opinion?_____

Referring physician information

Print referring physician name _____

Referring physician phone number_____ Fax_____

Requesting physician signature_____ Date _____

Please attach relevant diagnostic tests and progress notes.