Referral Form

Gillette Children's
Specialty Healthcare

Our Referral Management team can be contacted directly by phone (651-325-2200) or fax (651-726-2622). We look forward to caring for your patient.

Choose the Type of Referral
❒ Diagnose and Treat (Co-Manage)
❒ Consultation
❒ Transfer of Care

Please consult with me, the primary care provider, before making secondary referrals.
❒ Yes
❒ No

Referring Provider Information

UPIN Number / NPI

Referring Provider Name *

Primary Care Provider (❒ Same as Referring Provider)

Referring Provider Signature **Date**

Referring Clinic Information

Clinic Name

Street Address

Address Line 2

City

State **Postal / Zip Code**

Clinic Phone Number

Clinic Fax Number

Patient Information

Is family/patient aware of the referral? Yes ❒ No ❒
If No, please make them aware as soon as possible.

Patient Name *

Date of Birth *

Gender*
❒ Male
❒ Female

Patient Address

Street Address

Address Line 2

City

State **Postal / Zip Code**

Primary Contact

Relationship to Patient

Primary Phone Number

Alternative Phone Number

Preferred Language

Specialty Area to be Referred

Specific Name of the Provider I Would Like to Refer to

Continued on back.

*This information is required to complete a referral.

Patient Information (continued)

Reason for Referral:*

Diagnosis/Symptoms:*

Additional Documents:
Our specialists have requested documentation to assist us in the care of your patient. Please fax the following documents to medical records at 651-325-2137.

- Clinic notes, including diagnoses or problem lists.
- Relevant family history.
- Relevant test (lab or imaging) results.

*This information is required to complete a referral.