



**SPARROW REGIONAL CHILDREN'S CENTER
PEDIATRIC SUBSPECIALTY CLINIC
REFERRAL**

Referral line: (517) 364-5152

Referral fax: (517) 364-5147

Please circle the name of the provider you would like your patient to see. Thank you.

PULMONARY NEPHROLOGY ENDOCRINOLOGY GASTROENTEROLOGY SURGERY
 Dr. Autumn Clos Dr. Pinhas Geva Dr. Douglas Henry Dr. Safwan Malas Dr. Juda Jona

Patient Information (Please Print) Male or Female SS# _____

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Address/City/State/Zip: _____

Parents/Guardian Name: _____ Guardian DOB: ___/___/___

Telephone Numbers: Home # _____ Cell # _____ Emergency # _____

Insurance Information

Primary Insurance: _____ Policy/Contract #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____ SS# _____

Insurance Authorization Number: _____

Secondary Insurance: Type of Insurance: _____ Subscriber's Name: _____

Policy/Contract #: _____ Group #: _____

Primary Care Physician

Physician's Name: _____

Address/City/State/Zip: _____

Office Phone: _____ Office Fax: _____

Reason for referral (Signs/Symptoms) _____

To process this referral request in a timely manner, the following information must be received prior to scheduling an appointment: Growth charts, lab results, clinic notes, radiology reports, diagnostic reports, prior authorization for appointment and a copy of the insurance card.

➤ Please note that we will mail the family a letter with the date and time of the appointment(s).

Appointment Date: _____
 Time: _____

Dietitian: _____
 RN: _____

PFT Date: _____
 Time: _____

(For ages 5 and over only)

Thank you for choosing the Sparrow Pediatric Subspecialty Clinic for your patient's pediatric subspecialty needs.