Shodair CHILDREN'S HOSPITAL

Montana's Medical Genetics Program

2755 Colonial Drive, PO Box 5539, Helena, MT 59604
(406) 444-7500 1-800-447-6614 FAX (406) 444-1064

Please complete all fields below in order to facilitate a timely appointment for your patient

PATIENT REFERRAL FOR:

☐ General Genetics
☐ Metabolic
☐ Huntington's
☐ Cancer
☐ Other
☐ FAS or other exposures
☐ Prenatal

Date of Referral _____

SECTION 1: PATIENT INFORMATION

Last Name _____

First Name _____ Middle Initial _____

Birth Date _____ Sex: ☐ Male ☐ Female

Social Security # _____

☐ Child (0-18) ☐ Adult

Mailing Address _____

City _____ State _____ Zip _____

Phone #_____ Other Phone _____

*** *Ethnic Background - Check all that apply*** ☐ **European Caucasian**

☐ **Hispanic** ☐ **Native American** ☐ **African American** ☐ **Asian** ☐ **Other**

SECTION 2: RESPONSIBLE PARTY (COMPLETE FOR MINORS)

With whom does the patient reside?

Guardian/Parent(s) _____

☐ Biological ☐ Adoptive ☐ Foster

If child resides in foster care please complete the following:

Case Worker Name _____

Mailing Address _____

City/State/Zip _____

Phone # _____

~Please provide legal documentation of medical consent for patient~

Referring Physician
Address
City/State/Zip
Phone
Fax
Doctor's Medicaid Passport Provider No.
Primary Care Physician
Reason for Consult

Patient Demographic Information and Supporting Medical Records *MUST BE SUBMITTED* when making the referral

SECTION 3: INSURANCE INFORMATION (fill out completely)

Primary Insurance Co. Name _____

Name of Subscriber _____ Date of Birth of Subscriber _____

Social Security # of Subscriber _____ Passport Provider and Number _____

ID # _____ Group # _____

Secondary Insurance _____

Name of Subscriber _____ Date of Birth of Subscriber _____

Social Security # of Subscriber _____ ID # _____ Group # _____