Rady Children's Hospital San Diego

International Referral/Inquiry Form
3020 Children's Way, MC5101 San Diego, CA 92123-4282
Phone: 1-800-788-9029 Outside US: 001-800-788-9029 Fax: 858-966-4957
Email: refsvc@rchsd.org Web: www.rchsd.org

International Patient Services Referral/Inquiry Form

Thank you for contacting Rady Children's Hospital-San Diego! To provide you with excellent customer service, please fully complete the following form. Please attach any current medical records and return the form and information via e-mail or fax.

Today's Date (month/day/year): 01/18/2017

Contact Information:

Your Full Name: _____

Your Relationship to Patient: _____

Your Contact Phone Number: _____

Your Contact Email: _____

Your Primary Language: _____

Brief Description of Your Request: _____

_____

_____

_____

Patient Information:

Patient's Name (Last, First and Middle): _____

Patient's Date of Birth (month/day/year)**:**_____/_____/_____ Patient's Sex: ☐ Male ☐ Female

Permanent Address: _____

City/State/Zip Code /Country: _____

Temporary/Local Address: _____

Patient's Suspected Diagnosis: _____

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Family Information:

Mother:

Name of Mother:_____Date of Birth (month/day/year):_____/_____/____

Contact Number:_____Email: _____

Permanent Address: _____

City/State/Zip Code /Country: _____

Temporary/Local Address: _____

Employer:_____Occupation: _____

Employer's Address: _____

Father:

Name of Father:_____ Date of Birth (month/day/year):_____/_____/____

Contact Number:_____Email: _____

Permanent Address: _____

City/State/Zip Code /Country: _____

Temporary/Local Address: _____

Employer:_____Occupation: _____

Employer's Address: _____

Clinical Information:

Referring Physician or Referring Hospital: _____

Hospital Name:_____Address: _____

Physician's Name: _____

Physician's Contact Number:_____Email: _____

Please provide a copy of the current history and physical records, recent labs and pathology reports, radiology reports and films.

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Payment Information:

Please Check the Applicable Box: ☐ Self-Pay ☐ Government Sponsored ☐ Insured ☐ Other

If Insured, Name of Insurance Carrier: _____

Insurance Carrier's Phone Number: _____

Policy Holder ID Number:_____ Group Number: _____

Subscriber's Name:_____Date of Birth (month/day/year):_____/_____/___

If Government Sponsored, Name of Government Agency: _____

Government Agency's Phone Number: _____

If Other, Please Describe: _____

_____

_____

Travel Information:

When do you plan to travel to receive medical services at Rady Children's Hospital San Diego? _____

_____

How did you hear about us?

- ☐ Referring Physician
- ☐ Friend or Family Member
- ☐ Employer
- ☐ News/Media/TV
- ☐ Internet Search Engine
- ☐ Rady Children's Hospital San Diego Website
- ☐ Insurance Company
- ☐ Other:_____

IT IS IMPORTANT THAT YOU FULLY COMPLETE THIS REFERRAL/INQUIRY FORM

Please Note:

- **Once the intake form is completed and the medical records are received, one of our Physicians will review the documents to determine if the patient is appropriate for services at Rady Children's Hospital-San Diego.**
- **Please note, prior to any appointments, financial clearance will be required. We require full payment and/or payment of the estimated amount, at or prior to services received.**