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

Orthopedics - Request for Service Order

Pt. Name:_____

DOB:_____

MRN (If available):_____

Parent Name_____

Phone #_____Preferred time: ☐ 8-12, ☐ 12-5, ☐ after 5

Insurance: ☐ Medicaid, ☐ PPO, ☐ HMO, ☐ Self-pay / Other

Referring Provider Name: _____

Practice Name:_____

Date of Request:_____

Please attach patient's demographics

Step 1: When should patient be seen?

☐ ASAP (≤ 24 hours)

- For physicians new to Lurie Children's – Call the KidsDoc VIP Line **– (800) 540-4131, Option 4**
- For all other physicians, call the Lurie Children's Orthopedics Division Directly at (**312) 227-6190**

☐Within 2 weeks

☐> 2 weeks

Note: Chief Complaints marked with * are expected to be referred ASAP (≤ 24 hours)

Step 2: Identify Chief Complaint

☐ Fracture / Injuries

☐ Back Pain

☐ Cerebral Palsy

☐ Concussion

☐ Foot Deformity
☐ Infant ☐ Child & Adolescent

☐ Gait disturbance

☐ Hand Deformity

☐ Hip
☐ Infant ☐ Child & Adolescent

☐ In-toeing

☐ Joint Pain
Sports Related? ☐ Yes ☐ No
☐ Shoulder
☐ Elbow
☐ Wrist
☐ Hip
☐ Knee
☐ Ankle

☐ Leg length discrepancy

☐ Mass
Location_____

☐ Scoliosis

☐ Slipped capital femoral epiphysis (SCFE) *

☐ Spina Bifida

☐ Other_____

Step 3: Info Requested for Each Referral

1) **How long has the patient had the condition?**_____(days/weeks/months/years)
2) **Pertinent and Quick Patient History (1 – 2 sentences):**

_____

_____

3) **Questions referring provider wants answered by Specialist**

_____

_____

4) **Has the referring provider already spoken with a Lurie specialist about this referral?**

_____

5) **Is there a preferred provider to see the patient?**

_____

6) **Which location is preferred for the patient's appointment?**

_____

Ensure the following are sent to the Specialist (Orthopedics Fax #312.227.9404)

1. Imaging and X-Rays (provide disk if available)
2. Current Medications
3. Pertinent Labs

Please submit this request along with records to KidsDoc Fax #: 312.227.9832