Children's Hospital of Wisconsin

NEW™ Kids Triage Referral Form

PATIENT LABEL

Phone: 414-266-4112 Fax: 414-266-4709

Date: _____

Thank you for referring your patient to the NEW ™ Kids Triage at Children's Hospital of Wisconsin. Please complete the following information, verify insurance referrals and forward referral as indicated below. Once verified, a CHW representative will contact the family within 7 days to schedule an appointment in the NEW Kids Triage clinic.

Patient information

Patient Name: _____

Date of Birth: _____ Language: _____

Parent/Guardian Name: _____

Patient Address: _____

_____

Home Phone Number: _____

Work/Cell Number: _____

Insurance Carrier: _____

Referring Provider Information

Provider Name: _____

Provider Address : _____

_____

_____

Phone Number: _____

Fax Number: _____

***BMI MUST be at or greater than 85%.**

Date of Measurement: _____ Height: _____ Weight: _____ BMI: _____ BMI %: _____

***The patient MUST have one of the co-morbidities listed below or abnormal lab result in a category below to qualify for our program. Fasting lab values must be received with this referral.**

Date of fasting labs: _____

Total Cholesterol:	_____	<170 mg/dL	Insulin Level:	_____	<15 u/L
LDL Cholesterol:	_____	<110 mg/dL	Glucose:	_____	<100 mg/dL
HDL Cholesterol:	_____	>35 mg/dL	HA1C:	_____	<5.7%
Triglycerides:	_____	<125 mg/dL	AST:	_____	<50 u/L
			ALT:	_____	<35u/L

- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Non-alcoholic Steatohepatitis (NASH)
- ☐ Non-alcoholic Fatty Liver Disease (NAFLD)
  (Date of liver biopsy showing NAFLD/NASH _____)
- ☐ Hypertension (3 abnormal readings _____ _____ _____)
- ☐ Blount's Disease
- ☐ Pseudotumor Cerebri
- ☐ Slipped Capital Femoral Epiphysis (SCFE)
- ☐ Sleep Apnea (Date of sleep study _____)

Additional pertinent medical history: _____

_____

_____

**** Please fax this form to 414-266-4709 along with recent clinic note, lab values and growth chart.**

OFFICE USE ONLY

Date Received: _____

Date of Appointment: _____

Provider: _____

Referral denied reason: _____

Any additional comments: _____

APPLY DT BARCODE STICKER
MD Referral Accepted DT 346
MD Referral Denied DT 9901