



Lauves Pediatric

PATIENT REFERRAL FORM

Please complete this form and submit

PATIENT INFORMATION

Child's Full Name: _____

Date of Birth: _____

Male Female

Address: _____

City/State/Zip: _____

Insurance/ID#: _____

Diagnosis(es): _____

ICD Code(s): _____

Date of Last PCP _____

Visit: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Best Contact: Home Cell

PROVIDER INFORMATION

Physician/Practice

Name: _____

Physician NPI #: _____

Physician TPI #: _____

Phone #: _____

Fax #: _____

Practice Contact: _____

This referral is made because the patient requires skilled nursing care and may receive that care through a PDHC/PPECC – such as Lauves Pediatric.

The patient is ALSO being referred to be evaluated in the following areas: (Check all that apply):

Physical Therapy

Speech Therapy

Occupational Therapy

Physician Signature: _____

Date: _____

Pediatric Day Health Care Centers (PDHC) and Prescribed Pediatric Extended Care Centers (PPECC) allow minors from 6 weeks to 20 years of age with medically complex conditions to receive daily medical care in a non-residential setting. When prescribed by a physician, minors can attend a PDHC/PPECC to receive medical services such as nursing, speech therapy, physical therapy, occupational therapy, and developmental services appropriate for their medical condition and developmental status. The minor **MUST** be stable for outpatient medical services and require ongoing nursing care and other basic needs. Please feel free to contact us at _____ with any questions.