Newborn Follow-up Clinic

PH: 937-641-4189 Fax: 937-641-4500
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PLEASE PRINT (ALL INFORMATION IS REQUIRED)

Date of Request:_____

PATIENT INFORMATION

Patient's Name:_____
☐ M ☐ F DOB:_____MR# _____
Parent/Guardian Name(s): _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Preferred Contact Phone: ☐ Work ☐ Cell ☐ Home
Email Address: _____
Patient is in custody of: ☐ Parents ☐ Guardian ☐ CSB
Address: _____County:_____
City: _____State: _____ Zip: _____
1st Insurance: _____ Phone: _____
Cardholder: _____ ID#: _____
2nd Insurance: _____ Phone:_____
Cardholder: _____ ID#: _____

Insurance preauthorization is basses on eligible criteria
We will initiate preauthorization and contact patient to schedule appointment

Patient Gestational Age at Birth_____ weeks _____days
Current Weight:_____ ☐ kg ☐ lbs (please check)
Any Allergies: _____

PROVIDER INFORMATION

Primary Care Provider: _____
Referring:_____
Phone: _____
Fax:_____
Provider Signature (required): _____

Indications for consultation (check all that apply)

ICD-10 code:_____
☐ Birth weight ≤ 1500 grams
☐ Gestational age ≤ 32 weeks
☐ Grade III or IV intravententricular hemorrhage, periventricular leukomalacia or other abnormality on neuro-imaging.
☐ Neonatal meningitis
☐ Neonatal seizures
☐ Abnormal neurologic exam/ neurologic deficit
☐ Multiple congenital abnormalities
☐ Inherited metabolic disorder
☐ Documented congenital abnormalities (TORCHS)
☐ Neonatal Abstinence Syndrome
☐ Chromosomal abnormalities/ known syndrome:_____
☐ Other risk identified:_____
Additional information

We aim process referrals within one business day and contact the family within one week.
Accommodations may be made based on the patient's needs.

Dayton Children's use only:

Reviewed and approved on _____**date**
Appt Scheduled:
Date:_____Time: _____

Questionnaire mailed on_____**date**
Other information: