MercyOne Des Moines Pediatric Specialty Care Clinic
330 Laurel St., Suite 1200 Des Moines, IA 50314
Phone: (515) 643-5454 Fax: (515) 643-5460

Date: _____

MercyOne's Pediatric Gastroenterology and Surgery Referral Form

Patient

Patient Name: _____ DOB: _____ Gender:_____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip Code)

Parent: _____ Contact Number: {_____}_____ -_____ Alternate Number: {_____}_____ -_____

Does family need Interpreter: _____ Language: _____

Insurance

Primary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name & DOB: _____ Authorization # (if applicable): _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name & DOB: _____ Authorization # (if applicable):_____

****Please send copy of insurance card!****

Referring Provider / PCP Information

Referring Provider: _____ Phone Number: {_____}_____-_____

Contact Person: _____ Fax Number: {_____}_____-_____

Address: _____

Management of care requested: ☐ Consult Only ☐ Evaluate, Testing, and Treat ☐ On site TeleHealth

Reason for Referral: _____

Primary Care Physician: _____ Phone Number: {_____}_____-_____

Address: _____ Fax Number: {_____}_____-_____

Please fax completed referral form, demographics and all records pertaining to diagnosis (i.e. progress notes, labs, any imaging that has been done) to:

515.643.5460

****Appointments will NOT be made until ALL RECORDS are received! ****