Lauves Pediatric
PATIENT REFERRAL FORM

Please complete this form and submit along with THE MOST RECENT HISTORY AND PHYSICAL via fax at 318-741-5757 or via secure email to info@lauvespediatric.com

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 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 – Pediatric Day Health Care Center, 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) 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 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.*