



Rhode Island Hospital
A Lifespan Partner

Rhode Island Hospital
2 Dudley Street
Cooperative Care Building (Coop) 1st Floor
Providence, RI 02903 Phone: 401-444-5662 Fax: 401-444-4557
<http://www.lifespan.org/rih/services/ambulatory/>

PEDIATRIC ORTHOPEDIC

MR#

Session Times: Tuesday, Wednesday and Friday Mornings Only

Patient's Name: _____	Date of Referral: _____
Address: _____	Requesting Physician: _____
DOB: _____ Sex: _____	Address: _____
SS#: _____	_____
Interpreter Required Y N Language _____	_____
Phone: _____	Phone: _____
Insurance: _____	Fax: _____

PLEASE REVIEW THE FOLLOWING GUIDELINES AND INCLUDE THE REQUIRED INFORMATION WITH THE REFERRAL. *Please note that when required all blood-test results must accompany the referral. Patients with no insurance, in need of plain x-ray, may proceed to the Rhode Island Hospital (RIH) radiology department with an appropriate order from the referring clinician. US, CT, MRI must first be scheduled by the referring clinician and the patient must call 444-7850 to speak to a Patient Financial Services (PFS) advocate if they choose to seek financial assistance from RIH. Thank-you!*

Guidelines:	Please follow the guideline below to facilitate patient care.
Fractures (Include date and name of ER)	Can not accept Facial, Skull or Rib Fractures Include X-ray report if possible
Back Pain	Acute cases should be referred to Hasbro ED. Patients should be evaluated by PMD, and nonoperative measures attempted (PT, NSAIDS, rest) prior to referral.
Hip Dysplasia	Referral should be within 2 weeks of birth if possible Patient to BRING ORIGINAL ULTRASOUND or XR if taken.
Scoliosis	Curve >10 degrees by Cobb Measurement Standing PA and lateral scoli films obtained prior to referral
Hand problems	Refer to hand clinic
Knee Pain	For nonacute injury, patient should have 2 month trial of conservative management (PT, NSAIDS) prior to referral. X-Ray reports should be included with referral. Hard copies of films need to be sent with patient
Developmental delay/not walking	Ortho referral only if specific ortho concerns Initial eval by pedi neurology

Reason for Referral: _____

Signature: _____ Print Name: _____

Clinic Use Only: Date Received: _____ Coordinator Initials: _____ RN Initials: _____

Appointment Given _____ Patient Notified: _____

Triage Comments: _____

Signature: _____ Print Name: _____