NEW™ Kids
Triage Referral Form

PATIENT LABEL

Phone: 414-607-5280 Fax: 414-607-5288

Date: ____________________

Thank you for referring your patient to the NEW ™ Kids Triage at Children's Wisconsin. Please complete the following information, verify insurance referrals and forward referral as indicated below. Once verified, a Children's representative will contact the family within 7 days to schedule an appointment in the NEW Kids Triage clinic.

Patient information

Patient Name: ______________________________

Date of Birth: ______________________________

Language: ______________________________

Parent/Guardian Name: ______________________

Patient Address: ___________________________

Home Phone Number: ________________________

Work/Cell Number: __________________________

Insurance Carrier: ___________________________

Referring Provider Information

Provider Name: ______________________________

Provider Address: ____________________________

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Phone Number: ______________________________

Fax Number: ________________________________

***BMI for Age MUST be at or greater than 85%ile or Z score 1.03**

Date of Measurement: _____ Height: _____Weight: _____ BMI: _ BMI %ile or Z score: _

***The patient MUST have one of the co-morbidities listed below or abnormal lab result in a category below to qualify for our program. Fasting lab values must be received with this referral.**

Date of fasting labs: ___________

Total Cholesterol:	___________	<170 mg/dL
LDL Cholesterol:	___________	<110 mg/dL
HDL Cholesterol:	___________	>35 mg/dL
Triglycerides:	___________	<125 mg/dL
Insulin Level:	_________	<15 u/L
Glucose:	_________	<100 mg/dL
HA1C:	_________	**<5.7%*** **
AST:	_________	<50 u/L
ALT:	_________	<28u/L

*****If the HA1C is 6.5% or higher, contact the Pediatric Endocrine clinic - 414-266-2861**

- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Non-alcoholic Steatohepatitis (NASH)
- ☐ Non-alcoholic Fatty Liver Disease (NAFLD) (Date of liver biopsy showing NAFLD/NASH _____________)
- ☐ Hypertension (3 abnormal readings _______ _______ _____)
- ☐ Blount's Disease
- ☐ Pseudotumor Cerebri
- ☐ Slipped Capital Femoral Epiphysis (SCFE)
- ☐ Sleep Apnea (Date of sleep study __________)

Additional pertinent medical history: ____

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**** Please fax this form to 414-266-4709 along with recent clinic note, lab values and growth chart.**

OFFICE USE ONLY

Date Received: ________________ Date of Appointment: ____________ Provider:

Referral denied reason: ____

Any additional comments: ____

APPLY DT BARCODE STICKER
MD Referral Accepted DT 346
MD Referral Denied DT 9901