## University of Kentucky NICU Graduate Clinic Referral

Please email form to <a href="micugrad@uky.edu">nicugrad@uky.edu</a> or fax to 859-218-7585

Appointments scheduled only if a discharge summary is received with this form and this form is complete.

Patient Information	
Patient's name:  Date of Birth:UK MR#:  Phone Number:Alternate Phone Number:  Home Address:  Discharged home with:Relationship:  Is this a Foster Care placement:   Yes   No (If yes, name of state SW:)  Will this family need the services of an interpreter?   Yes   No (Language:)  PCP Name:PCP Phone:  Insurance Carrier:Insurance Type:   HMO   PPO   POS   Indemnity	
Reason for Referral	
Reason for referral (Please check all that apply.):    Premature birth (<32 weeks)	
Requesting Practitioner / Group	
Office Address:	Practitioner Name:  Telephone:  Are you the patient's primary care physician?   \[ \sum_{Yes}  \text{No.} \]

Please help us provide optimal care for your patient by faxing the inpatient discharge summary when available.