



Contact Center
Phone: (816) 234-3700
Toll Free Phone: (800) 800-7300
Fax: (816) 855-1776

Patient Information:

Last: _____ First: _____ Middle: _____

DOB: ____/____/____ Gender: _____

Reason for request:

Symptoms/History/Pertinent Information:

Parent/Guardian Information: Last: _____ First: _____

Email: _____ Preferred Phone: _____ Alt Phone: _____

Relationship: _____ Preferred Language (if not English): _____

Reason for Referral: _____

Please check and include all applicable documentation:

- Facesheet Clinic Notes Labs Radiology Images/Reports Growth Charts
- Insurance Information

Specialty Clinic Appointments:

*Requires Prior Authorization prior to referral.

Specialty Diagnostics: EKG Echocardiogram* EEG Hearing Test

SCAN (Child Abuse) Clinic: provider-to-provider call, **1 (800) 466-3729**

Prior Authorization #:

Diagnostic Testing Urgency: Urgent Routine

Appointment Urgency: Urgent Routine

Preferred Location (if available):

Missouri: Independence Joplin Kansas City Northland (KC) Springfield St. Joseph

Kansas: Great Bend Junction City Overland Park Topeka Wichita

Referring Provider Name: _____

NPI (if new referring provider): _____

Practice Name: _____

Office Phone: _____ Office Fax: _____

Primary Care Provider: Same as above Name: _____

Signature: _____

Date: _____