

State of Alaska
Division of Public Health
3601 C St, Ste. 322 Anchorage, AK 99503-5923
(907) 269-3405
Fax (907) 754-3425
Referral to Pediatric Cleft Lip & Palate Clinic

Date: _____

Patient Name – (Last, First): _____ Male Female

Date of Birth (mm/dd/yyyy): _____

Parent(s) or Guardian(s) Full Name: _____

Telephone Number(s): _____

Mailing Address: _____

Provider Making Referral – Name: _____

Provider Agency, Telephone & Fax #: _____

Diagnosis/Reason for referral: _____

Pediatrician or Primary Care Provider – Name, Telephone & Fax #: (if other than person making referral)

Other pertinent Information: (i.e. primary language if other than English, other diagnoses, imaging reports, lab tests results or pending diagnostic tests, etc.) _____

Has family been informed to contact their Public Health Nurse (PHN)? _____

If yes, who is the PHN? _____

Form Completed By: _____