Marshfield Clinic®

# Bardet-Biedl Syndrome Referral Questionnaire

Requesting provider _____ Self/Family request _____

Name _____ DOB _____

Age _____ Gender: ☐ Female ☐ Male

Address _____

City _____ State _____ ZIP code _____

Telephone number: Home _____ Cell _____

Other _____

E-mail address _____

## Family Information

Mother's name _____ DOB _____

Address _____

Father's name _____ DOB _____

Address _____

Primary insurance name _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Secondary insurance name _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Medical Assistance: State _____ Type _____

Insurance policy no. _____ Subscriber no. _____

Telephone number _____

Primary care provider name _____

Address _____

Office telephone number _____ Fax number _____

Specific concerns/issues you want evaluated at Bardet-Biedl Syndrome Clinic _____

_____

_____

_____

Have you/your child been previously evaluated at the National Institutes of Health: ☐ Yes ☐ No

**Send your completed questionnaire to Marshfield Clinic Marshfield Center, Pediatrics – 1A4, 1000 North Oak Avenue, Marshfield, WI 54449-5777. Or you can fax it to 715-387-5055.**