

Bardet-Biedl Syndrome Referral Questionnaire

Requesting provider _____		Self/Family request _____	
Name _____		DOB _____	
Age _____		Gender: <input type="checkbox"/> Female <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Send your completed questionnaire to Marshfield Clinic Research Institute, Clinical Research – 1R5, 1000 North Oak Avenue, Marshfield, WI 54449-5777. Or you can fax it to 715-389-3319.