



PROVIDER REFERRAL REQUEST FORM

REFERRING TO	Specialty:	Phone:	Fax:
	Practice Name & Address:		
	Please Schedule (select all that apply): <input type="checkbox"/> Urgent– Referring physician called _____ <input type="checkbox"/> Routine Appointment with Specific Physician listed: _____ <input type="checkbox"/> First Available with any Physician		
	Referring Provider's Name:	Phone:	Fax:
TYPE OF REFERRAL	<input type="checkbox"/> Evaluation consultation with treatment recommendations that primary care physician will continue to follow		
	<input type="checkbox"/> Evaluation consultation with assumed care for this condition		
	<input type="checkbox"/> Evaluation consultation with treatment recommendations and shared care		
PATIENT INFORMATION	Patient Full Legal Name:		DOB
	If patient is under 18 years old – Parent Contact Name:		
	Preferred Phone:		Best time to call:
	Special Patient Considerations:		
	Patient Insurance Information:		
	Patient's Primary Care Provider:		Phone:
GENERAL INFORMATION	Reason for Referral (Clinical Question):		
	Comments/Considerations Related to Clinical Question: Please include recent labs, pertinent imaging reports, medication list, problem list, allergies, and relevant clinical notes.		
	Patient aware of reason for referral? <input type="checkbox"/> Yes <input type="checkbox"/> No: Explain		

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION	Referral Accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No: Explain		
	Appointment Scheduled with:		Date & Time:
	<input type="checkbox"/> Patient refused scheduling <input type="checkbox"/> Patient prefers to contact specialist to schedule at a later date		
	Request for additional supporting clinical information (please detail):		
	Person completing confirmation:		Date of Confirmation: