[](https://goo.gl/93mCXF)**MEDICAL REFERRAL FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **RETURN COMPLETED REFERRAL REQUEST FORM TO** | | | | | | | |
| **ATTENTION** |  | | | **FAX** |  | | |
| **PHONE** |  | | | **EMAIL** |  | | |
| **FORM COMPLETED BY** | |  | **PHONE** |  | | **DATE** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **REFERRED BY** | | | |
| **REFERRING MD** |  | **PHONE** |  |
| **SPECIALTY** |  | **FAX** |  |
| **MD SIGNATURE** |  | **EMAIL** |  |
| **PCP** if different |  | **PCP PHONE** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | |
| **LAST NAME** |  | **FIRST NAME AND MI** |  | |
| **DATE OF BIRTH** |  | **FEMALE / MALE** |  | |
| **INTERPRETER REQUIRED?** |  | **LANGUAGE REQUIRED** |  | |
| **GUARDIAN NAME** |  | **GUARDIAN RELATIONSHIP** |  | |
| **PATIENT’S ADDRESS** |  | **CELL PHONE** |  | |
|  | **HOME PHONE** |  | |
|  | **WORK PHONE** |  | |
|  | **EMAIL** |  | |
| **REFERRAL DIAGNOSIS** |  | | **ICD-9** |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **SERVICE REQUESTED** | | | | | | |
| **REASON FOR REFERRAL** |  | | | | | |
| **PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.** | | | |  | | |
| **SERVICE / SPECIALTY REQUESTED** | |  | | **PHYSICIAN REQUESTED** | |  |
| **TYPE OF SERVICE REQUESTED** | |  | **CONSULTATION** |  | **TRANSFER OF CARE** new patient evaluation / management | |
| **ADDITIONAL COMMENTS** |  | | | | | |

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| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| **AUTHORIZATION REQUIRED?** | | | | |  | | | **YES** |  | **NO** | **AUTH #** | |  | **# OF VISITS** | |  | **AUTH EXP. DATE** | | |  |
|  | **PPO** |  | **HMO** |  | | | **OTHER** | | **INSURANCE PLAN** | | |  | | | | | | | | |
| **INSURANCE ID** | | |  | | | | | | **MEDICAL GROUP** | | |  | | | | **PHONE #** | |  | | |
| **INSURANCE HOLDER’S NAME** | | | | | |  | | | | | | **RELATIONSHIP TO PATIENT** | | |  | | | | **DOB** |  |

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