**MEDICAL REFERRAL FORM**

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

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

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| **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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