PROVIDER REFERRAL REQUEST FORM

REFERRING TO

Specialty:	**Phone:**	**Fax:**
Practice Name & Address:		

Please Schedule (select all that apply):

☐ Urgent-- Referring physician called _____

☐ Routine Appointment with Specific Physician listed:_____

☐ First Available with any Physician

Referring Provider's Name:	**Phone:**	**Fax:**

TYPE OF REFERRAL

☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow

☐ Evaluation consultation with assumed care for this condition

☐ Evaluation consultation with treatment recommendations and shared care

☐ Specialist to Specialist*–Secondary Referral
*Send copy of this referral to patient's primary care physician.

☐ Other (designate)_____

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:	Fax:

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? ☐ Yes ☐ No: Explain

PROVIDER REFERRAL CONFIRMATION

REFERRAL CONFIRMATION

Referral Accepted? ☐ Yes ☐ No: Explain

Appointment Scheduled with:	**Date & Time of Visit:**

Request for additional supporting clinical information (please detail):

☐ Patient prefers to contact specialist to schedule at a later date

☐ Patient declined appointment; Date:_____ Reason:_____

☐ Patient cancelled appointment on _____ and rescheduled for _____

☐ Patient cancelled appointment on _____ and did not wish to reschedule.

☐ Patient was NO SHOW for appointment on _____.

Person completing confirmation:	**Date of Confirmation:**