Physician Referral Form

Thank you for referring your patient. Please indicate the specialty to which you are referring your patient:

- ⊗ Allergy and Immunology
- ○ Arthritis and Rheumatology
- ○ Bariatric Surgery
- ○ Cardiology
- ○ Cardiothoracic Surgery
- ○ Dermatology
- ○ Endocrinology
- ○ Gastroenterology
- ○ General Surgery
- ○ Genetic Medicine
- ○ Gerontology
- ○ Hematology Oncology
- ○ Infectious Disease
- ○ Interventional Radiology
- ○ Medical Oncology
- ○ Nephrology
- ○ Neurology
- ○ Neurosurgery
- ○ OB/GYN
- ○ Ophthalmology
- ○ Oral and Maxillofacial Surgery
- ○ Orthopaedics & Spine
- ○ Otolaryngology
- ○ Pain Center
- ○ Palliative Medicine
- ○ Plastic and Reconstructive Surgery
- ○ Psychiatry
- ○ Pulmonary Care
- ○ Radiation Oncology
- ○ Rehabilitation Services
- ○ Sleep Disorders
- ○ Sports Medicine
- ○ Surgical Oncology
- ○ Transplant
- ○ Urologic Surgery
- ○ Vascular Surgery
- ○ Other_____
- ☐ Specific physician_____

Please provide the following so we can schedule an appointment:

O PERTINENT MEDICAL RECORDS

O INSURANCE AUTHORIZATION (IF REQUIRED)

Referring provider information

Name:	Practice:
City, state:	Phone:
Fax:	E-mail:
Office contact:	

Patient information

Patient name:	○ M ○ F
Street address:	
City, state:	Date of birth:
Parent/guardian:	

Please check preferred contact phone number:

O HOME: O CELL: O WORK:

Interpreter needed? ○ YES ○ NO LANGUAGE:

Primary Care Provider (IF DIFFERENT FROM REFERRING):

This visit is (MARK ONE):

○ **Routine** WITHIN 30 DAYS ○ **Semi-urgent** *WITHIN 2 WEEKS ○ **Urgent** *LESS THAN 48 HOURS

*For urgent appointments, please call

I am requesting: O CONSULT ONLY O ONGOING CARE O REFERRAL REQUESTED BY PATIENT

Patient's medical issue

ICD-10 code:

Please tell us what specific medical issue to address at this visit:

Information check list PLEASE ATTACH (WHERE APPLICABLE):

O PROGRESS NOTES	O PREVIOUS WORK UP FOR THESE SYMPTOMS
O LABS	O PATHOLOGY
O IMAGING	O MEDICATION LIST, ALLERGIES
O OTHER:	