

## SPECIALTY REFERRAL FORM

Date: \_\_\_\_\_

Referral to: \_\_\_\_\_  Or next available physician in this group

Referral Staff Contact Information: Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Please send a copy (front and back) of the patient's insurance card(s) or insurance information with this form**

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Parent (<18) \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Patient Phone (H) \_\_\_\_\_ (W): \_\_\_\_\_ Cell: \_\_\_\_\_

Special Needs:  Interpreter \_\_\_\_\_  Wheelchair Bound  O2  Other \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Pager # \_\_\_\_\_ NPI # \_\_\_\_\_

Patient's Primary Provider, if different \_\_\_\_\_ **please send a copy of consult note(s)**

### ***NEXT SECTION TO BE FILLED IN BY PROVIDER***

#### **Urgency:**

Next available appointment  Within 2-4 wks  Within 1 wk

Urgent (within 24 – 48 hrs)  Emergency (within 24 hrs) **provider to call specialist for urgent or emergent requests**

**Reason for consultation (primary dx or sx):** \_\_\_\_\_

#### **Consultation service requested (check all that applies):**

Single consultation for opinion on diagnosis and/or treatment: **please send patient back to me for follow-up**

Consultation and ongoing co-management of patient with Primary Provider

Please assume primary responsibility for ongoing care related to “reason for consultation”

Procedure: \_\_\_\_\_  Testing: \_\_\_\_\_

Diabetes Education - **complete specific form**  Other: \_\_\_\_\_

#### **Supporting documentation being sent to specialist:**

Problem list  Medication list  Allergy list

Referral letter  Office note(s) \_\_\_\_\_ (dates)

Labs \_\_\_\_\_

Imaging reports \_\_\_\_\_

Pertinent hospital records \_\_\_\_\_  Other: \_\_\_\_\_

#### **Requests for specialist:**

Additional providers to receive copy of this consultation: \_\_\_\_\_

Other instructions: \_\_\_\_\_

### ***NEXT SECTION TO BE FILLED IN BY SCHEDULING OFFICE***

**If Specialty office makes the appointment: Complete below and immediately return form to the referring physician**

**If Referring office obtains the appointment from the specialist's office: Complete below before sending to the specialist**

The Patient's appointment was made within the above requested time frame. Yes No (circle)

Please provide a reason if (NO) was circled: \_\_\_\_\_ Staff Initials \_\_\_\_\_

Appt Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_ Physician: \_\_\_\_\_

Patient notified of appointment: Date \_\_\_\_\_  In person  Mail  Fax  Phone  Voice mail