

Referred to Department: \_\_\_\_\_

Referred to Provider (if applicable): \_\_\_\_\_

Reason for Visit (Diagnosis and ICD-10): \_\_\_\_\_

Scheduling Instructions (i.e. next available): \_\_\_\_\_

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Legal Sex: Male \_\_\_\_ Female \_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\*Phone Number where patient can be reached between 8 am - 5pm\*

Referring Physician First Name: \_\_\_\_\_

Physician Last Name: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Provider NPI #: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City, State & Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

If requested physician is not available, can patient be seen by another provider?

Yes \_\_\_\_\_ No \_\_\_\_\_ Contact Referring Provider \_\_\_\_\_

**Please Include the following items when submitting the referral form:**

- Face Sheet to include Patient Demographics
- Copy of the patients' insurance card(s) front and back.
- Insurance Authorization (if required)
- Copy of valid photo ID
- Relevant medical records, like patient history, clinical notes, labs, imaging reports