

### 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. \_\_\_\_\_ Gender: M / F, 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

**Referral:**

Next available appointment  Within 2-4 wks  Within 1 wk  **Urgent (within 24 – 48 hrs) provider to call**

**Pediatric Sub-Specialty Referral:**

Next available appointment  **Urgent provider to call**

**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: \_\_\_\_\_

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

**Supporting documentation being sent to specialist:**

Problem list  Medication list  Allergy list  Growth Chart

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