MEDICAL REFERRAL FORM

RETURN COMPLETED REFERRAL REQUEST FORM TO

ATTENTION	
PHONE	
FAX	
EMAIL	

FORM COMPLETED BY

NAME	
PHONE	
DATE	

REFERRED BY

REFERRING MD	
SPECIALTY	
SIGNATURE	
PHONE	
FAX	
EMAIL	
PCP if different	
PCP PHONE	

PATIENT INFORMATION

LAST NAME	
FIRST NAME & M.I.	
DATE OF BIRTH	
FEMALE / MALE	
INTERPRETER REQ.?	
LANGUAGE REQ.	
GUARDIAN NAME	
Relationship to Pat.	
PATIENT ADDRESS	
CELL PHONE	
HOME PHONE	
WORK PHONE	
EMAIL	

SERVICE REQUESTED

REASON FOR REFERRAL	
PATIENT AWARE of reason for referral? If not, please explain.	
SERVICE / SPECIALTY REQUESTED	
PHYSICIAN REQUESTED	

INSURANCE INFORMATION

AUTHORIZATION REQUIRED?	☐ YES ☐ NO
AUTH. NO.	
NO. of VISITS	
AUTH. EXP. DATE	
☐ PPO ☐ HMO ☐ OTHER	**INSURANCE PLAN**
INSURANCE ID	
MEDICAL GROUP	
PHONE	
FAX	
INS. HOLDER NAME	
Relationship to Pat.	
DATE OF BIRTH	

REFERRAL DIAGNOSIS

REFERRAL DIAGNOSIS	
ICD-9	

TYPE OF SERVICE REQUESTED

☐	**CONSULTATION**
☐	**TRANSFER OF CARE** new patient evaluation / management

ADDITIONAL COMMENTS

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