

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX to: 681.342.3195

Referring Provider: _____ Referring Office Name: _____

Referring Provider Phone #: _____ Office FAX #: _____

Primary Care Provider: _____ Today's Date: _____

Person Completing Form: _____ Patient's SSN: _____

Patient's Name (F,MI,L): _____ Patient's Address: _____

Patient's Date of Birth: _____ Patient's Phone #: _____

Patient's Insurance/ Auth #'s: _____

Reason for Referral (please be specific): _____

Please Note:

The following information **MUST** accompany this referral: Most recent progress notes, labs, x-rays, MRI, EKG and CT reports.

Please have the patient bring films or CDs if test results are not accessible through EPIC.

Please include office notes, surgery reports, and any additional information pertinent to this referral.

Please send Insurance Authorization information as required by the patient's insurance, along with this referral.

We will notify the patient of appointment time and date.

Thank you for your referral.

Please do not hesitate to call us with any questions or concerns.