Print Form

Humboldt County Referral Initiative – Referral Form V3.29.16

Referring To

Date of Referral: | **Phone:** | **Fax:**

Specialty:

Referring to Provider Name, Practice Name & Address:

Please Schedule:
- ☐ Urgent (appointment within 7 days)
- ☐ First Available with any Provider or specific provider listed_____
- ☐ Routine Appointment with Specific Provider listed:

Referring from Provider's Name: | **Phone:** | **Fax:**

Supervising MD (if applicable):

Person Completing Referral: | **Practice Name:**

Type of Referral

- ☐ Medical Consultation: (Evaluate and advise with recommendations for management and send back to PCP)
- ☐ Procedural/Diagnostic test: (Specialist to confirm need for and perform procedure/diagnostic test if deemed necessary)
- ☐ Procedural/Diagnostic testing with consult: (Same as above with addition of consulting with patient regarding results)
- ☐ Co-management: (I prefer to share the care for the referred condition(PCP lead, first call))
- ☐ Co-management: (Please assume principal care for the referred condition(Specialist assumes care, first call))
- ☐ Specialist to Specialist - Secondary Referral - **Send copy of this referral to patient's PCP**
- ☐ Other (designate):

Patient Information

Patient Name: | **If child, Parent:**

DOB: | **Address:** | **City/Zip**

Daytime Phone: | **Patient Insurance Type:** ☐ **Partnership** ☐ **PPO** ☐ **HMO** ☐ **Medicare** ☐ **Work Comp** ☐ **Other**

Insurance Auth #: | ☐ **Copy of card attached (Front & Back)**

Clinical Information

Reason for Referral (*Clinical Question*):

Required Documentation:
- ☐ Problem list ☐ Medications lists ☐ Allergies ☐ Recent labs ☐ Pertinent imaging reports
- ☐ Pre-work(See Specialist's Clinical Guidelines) ☐ Relevant clinical notes (do not include non relevant records)
- ☐ Other:

Reason for referral discussed with patient? ☐ Yes ☐ No: Explain

Referral Tracking (to be completed by Specialty Office)

Referral Received Date: (Fax back to Referring provider to acknowledge receipt of referral)

Request for additional information (please detail):

Appointment Scheduled with: | **Date & Time:**
☐ Referral deemed routine (not urgent)

- ☐ Patient Cancelled/No showed for appointment ☐ Patient will schedule at a later date
- ☐ Unable to contact patient ☐ Patient did not call for appt ☐ Other: