

## New Patient Referral Form

### Instructions

Please fill out all required fields and attach relevant documents (lab results, imaging, pathology reports). Incomplete forms may delay care.

<p style="text-align: center;"><b>Patient Demographics</b></p> <ul style="list-style-type: none"> <li>• Name: _____</li> <li>• Date of Birth: ____ / ____ / ____</li> <li>• Gender: Male / Female</li> <li>• Address: _____ City: _____ State: _____ ZIP: _____</li> <li>• Phone: _____</li> <li>• Email: _____</li> <li>• Preferred Language: _____</li> <li>• Emergency Contact (Name &amp; Relationship): _____</li> <li>• Emergency Contact Phone: _____</li> </ul>	<p style="text-align: center;"><b>Insurance Information</b></p> <ul style="list-style-type: none"> <li>• Company Name: _____</li> <li>• Policy ID: _____</li> <li>• Group Number: _____</li> <li>• Insurance Phone: _____</li> <li>• Subscriber Name (if different): _____</li> <li>• Subscriber DOB: ____ / ____ / ____</li> </ul>
<p style="text-align: center;"><b>Referring Provider</b></p> <ul style="list-style-type: none"> <li>• Provider Name: _____</li> <li>• Practice Name: _____</li> <li>• Address: _____ City: _____ State: _____ ZIP: _____</li> <li>• Phone: _____</li> <li>• Fax: _____</li> <li>• NPI #: _____</li> <li>• Email: _____</li> </ul>	<p style="text-align: center;"><b>Authorization</b></p> <ul style="list-style-type: none"> <li>• Referring Provider Name (print): _____</li> <li>• Date: ____ / ____ / ____</li> <li>• Signature: _____</li> </ul>

### Clinical Details

- Reason for Referral: \_\_\_\_\_
- Urgency:  Routine (2-4 weeks)  Urgent (1 week)  Emergent (24-48 hours)
- Current Diagnosis/ICD-10: \_\_\_\_\_
- Onset Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Attach Clinical Summary
- Attach Past Medical History
- Attach Medications (name, dose, frequency)
- Attach Allergies (list or  None)
- Recent Test Results (attach reports):
  - Lab Work
  - Imaging
  - Pathology
  - Other Tests

### Attachments & Additional Info

- Attach medical records, notes, and test results.
- Include letters of necessity if needed for insurance.
- Additional comments: \_\_\_\_\_

### Receiving Provider Use

- Date Received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Reviewed By: \_\_\_\_\_
- Appointment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- Comments: \_\_\_\_\_

### Checklist

- Demographics complete
- Insurance info and prior auth included
- Provider details included
- Clinical info complete
- Attachments provided
- Signed and dated

**Submit completed forms and attachments via secure fax or electronic transfer.**