SANTA CLARA VALLEY

REQUEST For CONSULT/REFERRAL

Patient Name

Address

Phone

Medical Record #

Insurance Type or Coverage

Date _____

ORIGINATING CLINIC

Attending MD – *name & signature* *Resident, PA & NP requires attending signature*	Referring Clinic (name, address & phone)

STOP- All pertinent information must be complete & legible, or this referral will not be processed.

☐ **CONSULT** (Requesting opinion about a specific problem; requires feedback from consultant to provider initiating consult.)

☐ **REFERRAL** {Transferring care for a specific problem to another provider.)

Requested for _____

What Specialty

☐ **Routine** ☐ Within One Month ☐ Within Two Weeks ***Requires prior conversation w/Specialist. Print name of Specialists and date of conversation below.***

☐ ICD 10: 1) _____ 2) _____

3) _____ 4) _____

_____

Specialist's Name / Date

REASON FOR CONSULT / REFERRAL

(PLEASE INDICATE REASON FOR REFERRAL ALONG WITH ATTACHED PROGRESS NOTES, PERTINENT LABS, XRAYS, etc.)

(Please indication Reason for Referral)

_____

_____

_____

_____

_____

Please Fax Referral with all the listed information below:

☐ Current Demographic Information (Face Sheet)
☐ Progress Notes
☐ Reports (Labs, X-Ray & etc.)
☐ Approved Authorization
☐ Copy of Insurance Card

Original to Chart - Copy to SCVMC Referral Center