

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: <input type="checkbox"/> Urgent (appointment within 7 days) <input type="checkbox"/> First Available with any Provider or specific provider listed _____ <input type="checkbox"/> 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	<input type="checkbox"/> Medical Consultation: (Evaluate and advise with recommendations for management and send back to PCP) <input type="checkbox"/> Procedural/Diagnostic test: (Specialist to confirm need for and perform procedure/diagnostic test if deemed necessary) <input type="checkbox"/> Procedural/Diagnostic testing with consult: (Same as above with addition of consulting with patient regarding results) <input type="checkbox"/> Co-management: (I prefer to share the care for the referred condition(PCP lead, first call)) <input type="checkbox"/> Co-management: (Please assume principal care for the referred condition(Specialist assumes care, first call)) <input type="checkbox"/> Specialist to Specialist - Secondary Referral - Send copy of this referral to patient's PCP <input type="checkbox"/> Other (designate):			
	Patient Name:		If child, Parent:	
	DOB:	Address:	City/Zip	
	Daytime Phone:	Patient Insurance Type: <input type="checkbox"/> Partnership <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Medicare <input type="checkbox"/> Work Comp <input type="checkbox"/> Other		
	Insurance Auth #:		<input type="checkbox"/> Copy of card attached (Front & Back)	
	Reason for Referral (<i>Clinical Question</i>):			
Clinical Information	Required Documentation: <input type="checkbox"/> Problem list <input type="checkbox"/> Medications lists <input type="checkbox"/> Allergies <input type="checkbox"/> Recent labs <input type="checkbox"/> Pertinent imaging reports <input type="checkbox"/> Pre-work(See Specialist's Clinical Guidelines) <input type="checkbox"/> Relevant clinical notes (do not include non relevant records) <input type="checkbox"/> Other:			
	Reason for referral discussed with patient? <input type="checkbox"/> Yes <input type="checkbox"/> No: Explain			
	Referral Tracking (to be completed by Specialty Office)			
Referral Tracking	Referral Received Date:		(Fax back to Referring provider to acknowledge receipt of referral)	
	Request for additional information (please detail):			
	Appointment Scheduled with:		Date & Time: <input type="checkbox"/> Referral deemed routine (not urgent)	
	<input type="checkbox"/> Patient Cancelled/No showed for appointment <input type="checkbox"/> Patient will schedule at a later date <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Patient did not call for appt <input type="checkbox"/> Other:			