REFERRAL FORM

[Affix patient label]

Date: ____________________

☐ Dr. A ☐ Dr. B ☐ Dr. C ☐ Dr. D

Diagnosis: ____________________

Weight: __________

Problem: ☐ STAT (same day) ☐ Urgent (< 48 hours) ☐ Routine (> 48 hours)

Service: ☐ Consult only ☐ Testing only ☐ Follow-up ☐ Consult and treat

Referring to: ____________________

____

Phone: ____________________ Fax: ____________________

Send: ☐ Referral letter ☐ Letter dictated ☐ Dictated notes Dates: ____________________

Patient day or time preference: ____________________

☐ Referral faxed Date: ____________________

☐ Appointment confirmed Referring to: ____________________

Date/Time: ____________________

Location: ____________________

____

☐ Patient contacted Date: ____________________

☐ Message left for patient Date: ____________________

☐ Letter sent to patient Date: ____________________

Physicians: Check off labs required to be sent to specialist's office.
Referral coordinator: Check off labs that you send to specialist's office.

Req'd	Chemistry	Sent
	Most recent of the following labs:	
☐	All labs from __________	☐
☐	a. BMP/CMP	☐
☐	b. Lipid panel	☐
☐	c. A1C	☐
☐	d. Vitamin D	☐
☐	e. TSH, T4	☐
☐	f. CBC	☐
☐	g. BNP	☐
☐	h. Folic acid	☐
☐	i. B12	☐
☐	j. Iron studies	☐
☐	k. Troponin	☐

Req'd	Tests	Sent
☐	Spirometry	☐
☐	Echocardiogram	☐
☐	ECG	☐
☐	EEG	☐
☐	EMG	☐
☐	Stress test	☐

Req'd	Radiology	Sent
☐	CT scan of __________	☐
☐	X-ray of __________	☐
☐	MRI of __________	☐
☐	US of __________	☐

Notes:

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