

REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to the UCSF service to which you are referring your patient.

- ▶ Fax numbers can be found online at www.ucsfhealth.org/prd2010
- ▶ Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call (800) 444-2559 and ask for either the UCSF practice or the Referral Liaison Service.

Date:	From:
No. of pages:	Title:
To UCSF practice:	Phone:
Fax:	Fax:

PATIENT INFORMATION

Name of patient: _____

DOB: _____ Interpreter needed: Yes No Language: _____

Home phone: _____ Work or cell phone: _____

If child, name of parent: _____

Address: _____

City: _____ Zip: _____

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9: _____

Name of UCSF MD (if known): _____ Specialty: _____

Reason for consultation: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Signature: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.