Regional One Health | Specializing in tomorrows.

Specialist Referral Request Form
Please fax to (901) 545 - 6092

Patient Demographics

Name: _____ **DOB:** _____

Gender Identity: _____ **Preferred Language:** _____

Residence Address: _____

Mailing Address *(if different than Residence Address)*: _____

Mobile Phone: _____ Alternate Phone: _____

PCP Name *(if different than Refer from Provider)*: _____

Patient Insurance Information

Primary Insurance: _____ **Member/Subscriber #:** _____

Referral Authorization # *(if applicable)*: _____ Exp. Date: _____

Number of Visits: _____

Refer from Provider and Location

Refer from Provider Name: _____ Medical Specialty: _____

Refer from Location Name: _____ **Location Phone #:** _____

Location Address: _____ **Location Fax #:** _____

Referral Contact Name: _____ **Referral Contact Phone #:** _____

Requested Service

Medical Service/Specialty: _____

Referral Reason: _____

***Codified Referral Reason *(ICD-10 Codes)*:** _____

Referral Type: ☐ **Consult** ☐ **Evaluate & Treat** ☐ **Co-Management**

Refer to Location *(select one)*: ☐ **Downtown** ☐ **East** ☐ **No Preference**

Refer to Provider *(if preference known)*: _____

Priority: ☐ **Routine** ☐ **Urgent** *(within 7-10 days based on availability)*

Comment: _____

_____

Please attach ALL relevant: ☐ **Office Notes** ☐ **Labs**

☐ **Diagnostic Testing** ☐ **Insurance Card(s)**