

# REFERRAL FORM



Thank you for choosing to refer your patient to UCSF. To start the referral process, please complete this form and fax it directly to the clinic.

- To find a clinic fax number, search at [ucsfhealth.org/refer-a-patient](https://ucsfhealth.org/refer-a-patient).
- Send brief, pertinent medical records, including test results and imaging, that support the consultation.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call (800) 444-2559.

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

## PATIENT INFORMATION

Name of patient \_\_\_\_\_

DOB \_\_\_\_\_

Home phone \_\_\_\_\_  Work phone  Cell phone \_\_\_\_\_

Parent or caregiver \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance \_\_\_\_\_

## CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9/10 \_\_\_\_\_

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 \_\_\_\_\_

Primary care provider \_\_\_\_\_ 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.