UCSF Medical Center | UCSF Benioff Children's Hospital

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/ICD10

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: