Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 695-2840
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Surgery

How soon: ❑ **Non-Urgent**-Fax to (603) 676-4080 ❑ **Soon** (Within 3-4 weeks) Fax to (603) 676-4080
❑ **Urgent** Fax to (603) 640-1909

Reason/Diagnosis: _____

_____

_____

Specific question to be answered by consult: _____

_____

Please indicate your intention of this referral by placing an "X" in all boxes that apply:

❑ Consult only ❑ Second Opinion ❑ Consult and Treatment ❑ Consult and Diagnostic testing

Other: (Please explain): _____

_____

Data previously obtained to evaluate symptoms: (please indicate dates that address this issue)

Labs: _____

Notes: _____

Radiology: _____

Other: _____

Before faxing this referral request to office at appointment location, please check that the following information which is included so that we may complete this request.

❑ Pertinent office notes ❑ Patient demographics ❑ Recent medication list
❑ Insurance referral (if required) (if separate) ❑ Recent test results