

Dartmouth Hitchcock Medical Center

Phone: Fax: Medically Urgent Fax:

(603) 695-2840 (603) 676-4080 (603) 640-1909

| | Referring Provider: _ | | Office Phone: | | | |
|--|--|---|-------------------------------|---------------------------------------|--|--|
| Name: | Practice Name: | | Fax: | | | |
| Cell PhoneHome PhoneWork PhoneAddress:upplied interpreter be needed for this appointment? \[\] No \[\] Yes \[\] Language: | Practice Address | tice AddressPCP Name: | | | | |
| Address:upplied interpreter be needed for this appointment? | Patient Name: | | | MRN# | | |
| Insurance: | DOB: | Cell Phone | Home Phone | Work Pl | none | |
| Subscribers Name: Subscribers DOB Subscrib | Mailing Address: | | | | | |
| great for Surgery Don: Non-Urgent-Fax to (603) 676-4080 Soon (Within 3-4 weeks) Fax to (603) 676-4080 Int Fax to (603) 640-1909 Int Consult and Diagnosis: Indicate your intention of this referral by placing an "X" in all boxes that apply: Soult only Second Opinion Consult and Treatment Consult and Diagnostic testing (Please explain): Treviously obtained to evaluate symptoms: (please indicate dates that address this issue) | Will a supplied interp | reter be needed for this app | pointment? ☐ No ☐ Yes | Language: | | |
| rral for Surgery on: | Health Insurance: | | Subscribers | Name: | | |
| Soon (Within 3-4 weeks) Fax to (603) 676-4080 Int Fax to (603) 640-1909 Int Fax to (603) 676-4080 Int Fax to (603) 676-408 | Policy #: | | Group# | Subscribers | DOB | |
| Soon (Within 3-4 weeks) Fax to (603) 676-4080 Int Fax to (603) 640-1909 Int Fax to (603) 676-4080 Int Fax to (603) 676-408 | Referral for Su | urgery | | | | |
| indicate your intention of this referral by placing an "X" in all boxes that apply: sult only | How soon: ☐ Nor | n -Urgent -Fax to (603) 676- | 4080 Soon (Within 3 | -4 weeks) Fax to (603 |) 676-4080 | |
| indicate your intention of this referral by placing an "X" in all boxes that apply: sult only | Reason/Diagnosis: | | | | | |
| indicate your intention of this referral by placing an "X" in all boxes that apply: sult only | | | | | | |
| indicate your intention of this referral by placing an "X" in all boxes that apply: sult only | | | | | | |
| Second Opinion | Specific question to | o be answered by consult | : | | | |
| (Please explain): | Please indicate your | intention of this referral by | placing an "X" in all boxes t | hat apply: | | |
| reviously obtained to evaluate symptoms: (please indicate dates that address this issue) ogy: | ☐ Consult only | ☐ Second Opinion | ☐ Consult and Treatme | ent 🖵 Consult | and Diagnostic testing | |
| pgy: | Other: (Please explain | in): | | | | |
| pgy: | | | | | | |
| pgy: | Data previously obt | tained to evaluate sympto | ms: (please indicate dates | that address this issue | ······································ | |
| ogy: | Labs: | | | | | |
| | Notes: | | | | | |
| | Radiology: | | | | | |
| | Other: | | | · · · · · · · · · · · · · · · · · · · | · · · · · · · · · · · · · · · · · · · | |
| | ☐ Consult only Other: (Please explained in the consult only) Data previously obtously obtous: Labs: Notes: Radiology: | □ Second Opinion in): tained to evaluate sympto | Consult and Treatme | ent | e) | |
| faxing this referral request to office at appointment location, please check that the following information | | • | | Dogot modication !! | . 4 | |
| s included so that we may complete this request. | ☐ Pertinent office not ☐ Insurance referral | tes | • . | ☐ Recent medication lis | il | |