

## Outpatient Appointment Referral Form D-H Connection Center

Thank you for this referral. Please complete the information below, so we may process your request in a timely manner. We will contact your patient prior to scheduling and your office will be notified when an appointment has been secured.

Referring provider: \_\_\_\_\_ Office #: \_\_\_\_\_

Practice name: \_\_\_\_\_ Fax #: \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Staff physician: (if different than above): \_\_\_\_\_

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

Former name(s): \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Is a D-H Interpreter needed for this appointment? YES NO

PCP: (if different than above): \_\_\_\_\_ Office #: \_\_\_\_\_

\*\*Insurance – (Required Field): \_\_\_\_\_ Policy #: \_\_\_\_\_

\*\*Insurance Address: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber #: \_\_\_\_\_

### Presenting Symptoms/Diagnosis

\_\_\_\_\_  
\_\_\_\_\_

### Urgency

**EMERGENT MEDICAL ISSUE – Please call the section to arrange the appointment (24 – 72 hours)**

**MEDICALLY URGENT** (72 hours – 2 Weeks)

*May require provider to provider phone call*

**PATIENT PREFERENCE**

*D-H will work with patient to schedule*

**OTHER:**

\_\_\_\_\_

### Notes associated with this request:

Notes are available in eD-H (D-H EMR)

Pertinent office notes with medication /dosage listing are attached

Pertinent lab and radiology reports are attached

Other: \_\_\_\_\_

### Clinic Request

Section/Clinic: \_\_\_\_\_

Consultation with specific provider, if available:

\_\_\_\_\_

### Management of Care

Evaluate and treat

Second opinion

Assume a subset of care

\_\_\_\_\_

*We will contact your patient prior to scheduling unless instructed otherwise.*

### Other Instructions:

\_\_\_\_\_  
\_\_\_\_\_