Dartmouth-Hitchcock
MEDICAL CENTER

Toll free: 1-866-DHMC DOC (346-2362)
Locally, dial (603) 653-1999
Fax: (603) 676-4080

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:

_____

_____