

Outpatient Appointment Referral Form

Lebanon

Toll free: 1-866-DHMC DOC (346-2362)

Locally, dial (603) 653-1999

Fax for Routine Visits: (603) 676-4080

Fax for Medically Urgent: (603) 640-1909

Concord/Keene/Manchester/Nashua:

Toll free: 1-866-833-4685

Phone: (603) 640-7680

Fax: (603) 727-7776

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): _____ If patient under 18, Parent/Guardian Name: _____

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 #: _____

**Group #: _____ Subscriber Name: _____ Subscriber DOB: _____

**Please include copy of the card with records

Clinic Requested

Section/Clinic: _____

Consultation Provider Request (if available) _____

Presenting Symptoms/Diagnosis

- Management of Care
- Evaluate and treat
- Second Opinion
- Assume a subset of care

Urgency

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

- Medically Urgent (72 hours-2 Weeks)
May require a provider-to-provider phone call
- Routine/Non-Urgent
D-H will work with patient to schedule

Notes associated with this request:

- Other instructions: _____
- _____
- Notes are available in eD-H EMR
- Pertinent office notes with medication/dosage listing are attached
- Pertinent lab and radiology reports are attached