SSMHealth

REFERRAL TO SSM HEALTH

Please fax this completed form and all relevant clinical information to _____

DEMOGRAPHIC

☐ Female
☐ Male

Name:_____ DOB:_____/_____/_____

Phone:(____)_____ – _____ Referring Clinic MRN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Interpreter Needed? ☐ Yes ☐ No Language: _____

SCHEDULING

We will contact your patient to schedule. **Patients will not be scheduled until all information has been received.**

Preferred appointment date:_____

After: _____ Before:_____

Additional scheduling instructions:

REFERRING PROVIDER

Today's Date: _____

Clinic Name: _____

Direct Phone #: (____) _____ – _____

Referring Provider: _____

Clinic Contact Person: _____

Clinic Fax #: (____) _____ – _____

INSURANCE *(to ensure coverage)*

Insurance: _____ MA # *(if applicable):*_____

Subscriber ID #:_____

CLINICAL

IMPORTANT! Along with submission of this referral form, please ***include the following records***:

- Clinic Notes
- Medication List
- Imaging and testing results
- Other _____

Referred to Specialty: _____

Indication / Diagnosis Code _____

Has the patient been treated for this condition before? ☐ Yes ☐ No

Level of Care Request: ☐ I request **a consultation (opinion)** regarding the medical condition above (check all that apply):

(Select one category): ☐ Diagnosis ☐ Treatment recommendation.

☐ I am not seeking an "opinion". I request you take over the evaluation and management of the medical condition, above. **This is a transfer of care for this condition.** I will continue to care for this patient's other conditions.

☐ Perform _____(procedure/treatment) and return patient for further care.

☐ Other: _____

Referring Provider Signature *(required)***:** _____ **Date:** _____