

## REFERRAL REQUEST FORM

Thank you for referring your patient to Valley Medical Center. This form is to be completed by the outside referring provider or designee. Specialty clinic and services information, including phone and fax numbers are at [Valleymed.org/referral guide](http://Valleymed.org/referralguide).  
Note: VMC specialists will return patients to the referring provider for ongoing care unless advanced care is recommended.

Patient Name (Last Name, First Name, Middle Initial)		Date
Legal Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Patient Preferred Language for Healthcare Communication	
Date of Birth	Patient Home Telephone	Patient Alternative Telephone
Patient Home Address		
Patient Insurance Company and Plan(s)		
REFERRAL FROM:		
Referring Provider (Last Name, First Name, Middle Initial)		NPI
Referring Provider Contact Telephone		Referring Provider FAX
Referring Provider Address		
Patient's Primary Care Provider, If Different Than Referring Provider (Last Name, First Name, Middle Initial)		
REFERRAL TO:		
VMC Specialty Clinic/Service		Clinic Location (If applicable)
Specialty Provider (If applicable; Last Name, First Name)		
REFERRAL URGENCY:		
<input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> STAT (Requires discussion between referring and specialty providers)		
PATIENT DOCUMENTS INCLUDED (Check boxes that apply):		
<input type="checkbox"/> Recent Chart Notes <input type="checkbox"/> Lab Results <input type="checkbox"/> Diagnostic Imaging (relevant to referral diagnosis)		
REASON FOR REFERRAL (Include diagnosis and if patient has been referred to this clinic previously):		
PROVIDER SIGNATURE		Date

