VALLEY MEDICAL CENTER

WE ARE Valley

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.
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 ☐ Male ☐ Female ☐ 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:		
☐ Routine ☐ Urgent ☐ STAT (Requires discussion between referring and specialty providers)		
PATIENT DOCUMENTS INCLUDED (Check boxes that apply):		
☐ Recent Chart Notes ☐ Lab Results ☐ Diagnostic Imaging (relevant to referral diagnosis)		
REASON FOR REFERRAL *(Include diagnosis and if patient has been referred to this clinic previously):*		
PROVIDER SIGNATURE		**Date**

VMC Patient Label