

# Referral Form

Referral is URGENT

Thank you for choosing to refer your patient to the John Muir Health/UCSF Health Berkeley Outpatient Center. To start the referral process, please complete this form and fax it directly to the clinic.

- Fax this form to **(510) 985-5202**.
- Send brief, pertinent medical records, including test results and imaging that support the consultation if available.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call **(510) 985-5200**.

Date: _____	From: _____
No. of pages: _____	Title: _____
To: <b>Berkeley Outpatient Center</b>	Phone: _____
Fax: <b>(510) 985-5202</b>	Fax: _____

## PATIENT INFORMATION

Name of patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Home phone: \_\_\_\_\_  Work phone  Cell phone

Parent or caregiver: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance: \_\_\_\_\_

## CONSULTING REQUEST INFORMATION

Diagnosis/ICD 10: \_\_\_\_\_

Name of MD (if known): \_\_\_\_\_ Specialty: \_\_\_\_\_

Reason for procedure: \_\_\_\_\_

Reason for visit:  New patient  Second opinion  Transfer care  Surgical procedure

Is authorization required?  Yes  No If yes, authorization number: \_\_\_\_\_

## REFERRING PHYSICIAN INFORMATION

Referring MD: \_\_\_\_\_ Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Primary care provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

**THIS FORM MUST BE COMPLETED AND FAXED TO BERKELEY OUTPATIENT CENTER PRIOR TO SCHEDULING**

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.