



PROVIDER  
REFERRAL SERVICE  
Phone: 612-672-7000  
Toll free: 833-623-5011  
Fax: 651-643-0250

# Request for Referral

To be used by providers and their staff

## REFERRING PROVIDER INFORMATION

Referring Provider Name\* \_\_\_\_\_  
Referring Clinic Name\* \_\_\_\_\_  
Referring Clinic Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Referring Clinic Phone Number\* \_\_\_\_\_  
Referring Clinic Fax Number \_\_\_\_\_  
Referring Clinic Contact name (if different from referring provider) \* \_\_\_\_\_  
Referring Clinic Contract Direct Number (if different than main clinic number) \_\_\_\_\_

## PATIENT INFORMATION

Patient First Name\* \_\_\_\_\_  
Patient Middle Name \_\_\_\_\_  
Patient Last Name\* \_\_\_\_\_  
Patient Gender:  Male  Female  Other \_\_\_\_\_  
Patient Date of Birth (DOB) \_\_\_\_\_  
Patient Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Patient/Legal Guardian Name (if patient is a minor) \_\_\_\_\_  
Patient Phone Number\* \_\_\_\_\_

## REQUESTED APPOINTMENT

Reason for Appointment (symptoms or diagnosis) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Specialty Requested\* \_\_\_\_\_  
Provider Requested (if any) \_\_\_\_\_

