Washington University Physicians

Your Practice Name _____

STREAMLINED REFERRAL PROGRAM

PHONE: 314-747-1000 or 866-747-1001 FAX: 314-273-0440 or 314-273-0438

DATE: _____ **REFERRING PROVIDER** ☐ _____, **MD**
☐ _____, ____

OFFICE CONTACT NAME: _____ **EMAIL:** _____

PH: _____ **EXT:** ____ **FX:** _____ ☐ **Adult Referral** ☐ **Pediatric Referral**

*****PLEASE MAKE SURE PATIENT HAS BEEN INFORMED OR IS AWARE OF REASON FOR REFERRAL*****

Patient's Name: _____ **DOB**: _____

Social **S**ecurity: _____ **I**nsurance **C**arrier: _____

Insurance **P**lan: _____ **I**nsurance ID #: _____

Patient **BEST N**umber: _____ **O**ther **N**umber: _____

Requested **S**pecialty: _____ **S**pecialist **F**ull **N**ame: _____

Reason for **R**eferral: **Dx**:_____

Evaluation **W**ithin: ☐ **URGENT** ☐ **F**irst **A**vailable

☐ **C**onsult **O**nly ☐ **P**rocedure ☐ **C**onsult and **T**reatment ☐ **S**econd **O**pinion ☐ **T**ransfer of **C**are

Interpreter **N**eeded? ☐ **Y**es **L**anguage _____ ☐ **N**o

Pertinent **R**ecords **A**vailable ☐ **Y**es ☐ **N**o (Please fax request when ALL records are available)
☐ **N**ot **A**vailable ☐ **R**equesting ☐ **C**are **E**verywhere

☐ **Faxed #_____ pages**

*****Please include pertinent demographics, progress notes, diagnostic testing, labs, pathology reports, imaging with request*****

Please inform the patient that there is a review process on most referrals.
Please allow 7-10 business days before requesting an update.