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:** _____ **Ext:** _____

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

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

**P**atient's Name: _____ **DOB**: _____

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

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

**P**atient **BEST N**umber: _____ **O**ther **N**umber: _____

**R**equested **S**pecialty: _____ **S**pecialist **F**ull **N**ame: _____

**R**eason for **R**eferral: **Dx**:_____

**E**valuation **W**ithin: ☐ **URGENT** ☐ **F**irst **A**vailable

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

**I**nterpreter **N**eeded? ☐ **Y**es **L**anguage _____ ☐ **N**o

**P**ertinent **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.**