

Patient Referral and Recommendation Form

Instructions: Please complete all sections of this form prior to printing. This document is intended for clinical referral purposes.

1. Referring Provider Information

Provider Name: Facility/Practice Name:
Phone Number: Email Address:
Fax Number: NPI Number:

2. Patient Information

Patient Full Name: Date of Birth:
Gender: Phone Number:
Street Address:
Insurance Provider: Policy/ID Number:

3. Receiving Specialist / Facility

Recipient Specialist Name: Specialty:
Facility Name: Contact Phone:

4. Clinical Reason for Referral & Recommendations

Urgency Level (e.g., Routine, Urgent):
Primary Diagnosis / ICD-10 Code:
Reason for Referral:
Clinical Recommendations:
Relevant Medications / History:

5. Authorization & Signatures

By signing below, the referring provider authorizes this clinical referral and the release of necessary medical records to the receiving specialist.

Referring Provider Signature: Date: