THE POLYCLINIC

Specialty Clinic Referral Request

Please print clearly and fax to the specific specialty clinic needed.
For urgent requests, please call the specialty clinic directly.

Please make sure to include all clinical record information needed including test or lab reports.

Date of referral _____

Demographic Information (Attaching demographic sheet is acceptable)

Patient Last Name: _____ First Name: _____ MI: _____

Patient DOB: _____ Sex: Male ☐ Female ☐ Patient Phone: _____

Insurance Information

Please attach a front and back copy of insurance card.

Interpreter needed? Yes ☐ Yes, specify language: _____

If patient's insurance requires authorization, please secure prior to submitting referral.

Auth # _____ Auth Dates: _____

Category of Referral - check all that apply

- ☐ Diagnostic Evaluation
- ☐ Medical Management
- ☐ Medication Evaluation/Management
- ☐ Special Request _____
- ☐ Surgical Options
- ☐ Transfer of Care
- ☐ Second Opinion

Referred to:

Polyclinic provider name requested: _____

Polyclinic specialty clinic requested: _____

Clinical reason for this referral, including relevant health history
(Please indicate if conservative treatment has been completed).

_____

_____

Diagnostic Codes (ICD-10):

_____

Referring Provider Information

Provider name (Primary Care or Other): _____

Name of clinic/facilty: _____

NPI# _____ Contact number: _____ Fax: _____