



## Specialist Referral Request Form

### Request for Specialist Consultation

Referral Number: **13283**

Date of Referral (YYYY/MM/DD):

### Referring Provider Information

Referring Provider Name:

Clinic / Organization:

Phone:

Fax / Secure Email:

### Patient Information

Patient Name:

Medicare Number:

Date of Birth (YYYY/MM/DD):

Phone:

### Requested Specialist

*Select from the list.*

- Orthopedic Surgeon
- Neurosurgeon
- Physical Medicine Specialist / Psychiatrist
- Neurologist
- Rheumatologist
- Dermatologist
- Pain Medicine Specialist (Anesthetist)

### Specialist Contact Information

Name:

Clinic / Organization:

Phone:

Fax / Secure Email:



## Reason for Request / Clinical Details

*Your expertise regarding this case is appreciated.*

### Attachments (if applicable)

- Clinical Notes
- Imaging Reports
- Laboratory Results
- Other:

### Additional Recipients (CC)

*Copied providers are for information and continuity of care.*

- Family Physician / MD
- Nurse Practitioner
- Other Provider (specify):

Name(s):

Clinic / Organization:

Fax or Secure Email:

### Referring Provider Signature

Signature:

Date (YYYY/MM/DD):