PROVIDER REFERRAL SERVICE
Phone: 612-672-7000
Toll free: 888-318-3627
Fax: 612-884-0659

Request for Referral

To be used by providers and their staff

REFERRING PROVIDER INFORMATION

Referring Provider's Name* _____

Referring Clinic Name* _____

Referring Clinic Address _____

City _____ State _____ Zip _____

Referring Clinic Phone Number* _____

Referring Clinic Fax Number _____

Referring Clinic Contact name (if different from referring provider) * _____

Referring Clinic Contract Direct Number (if different than main clinic number) _____

PATIENT INFORMATION

Patient's First Name* _____

Patients Middle Name _____

Patient's Last Name* _____

Patient Gender: ☐ Male ☐ Female ☐ Other _____

Patients Date of Birth (DOB) _____

Referring Clinic Address _____

City _____ State _____ Zip _____

Patient/Legal Guardian Name (if patient is a minor) _____

Patient's Phone Number* _____

REQUESTED APPOINTMENT

Reason for Appointment (symptoms or diagnosis) _____

_____

_____

_____

Specialty Requested* _____

Provider Requested (if any) _____