REFERRAL FORM

UCSF Benioff Children's Hospitals

Fax Oakland Referrals to 510-985-2202	**Fax San Francisco Referrals to 415-353-4485**
Preferred location: ☐ Brentwood ☐ Greenbrae ☐ Oakland	Preferred location: ☐ Fremont ☐ Greenbrae ☐ Los Gatos
☐ San Ramon ☐ Walnut Creek ☐ Next available, any location	☐ Modesto ☐ Redwood Shores ☐ San Francisco
☐ Other: _____	☐ San Mateo ☐ Santa Rosa ☐ Next available, any location
☐ URGENT	☐ Other: _____ ☐ URGENT

From: Date: No. of pages:

Phone: ( ) Fax: ( ) Referred to Provider (opt.):

Referred to Specialty/Clinic:

PATIENT INFORMATION

Patient First Name: Last Name:

DOB: Gender:

Home phone: ( ) ☐ Work phone *OR* ☐ Cell phone: ( )

Interpreter needed: ☐ Yes ☐ No Language:

Parent/Guardian: Relationship to Patient:

DOB: Email:

Address:

City: State: Zip:

CONSULTATION REQUEST INFORMATION

Diagnosis: ICD-10:

Reason for referral:

Include brief pertinent medical records that support the consultation: ☐ Clinical notes ☐ Growth charts ☐ Imaging ☐ Labs

REFERRING PHYSICIAN INFORMATION

Referring MD: Specialty:

Phone: ( ) Fax: ( )

Office Name:

Address: City: State: Zip:

Signature:

PCP INFORMATION

PCP Name: Phone: ( )

INSURANCE INFORMATION

☐ **Include copy of insurance card (both sides)**

Subscriber Name: DOB:

Health Plan: Member ID:

Group #: Authorization #:

Secondary Insurance, if any:

By providing the information requested and signing above, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.

500-0611i (Rev. 0322)