Adventist Health Referral Request

We appreciate the opportunity to care for your patient.

Fax: 800-305-0456 | Phone: 877-906-3388

☐ Routine Date: _____

☐ Urgent Number of Pages: _____

Referring provider information:

Referred by (MD): _____ Medical Group: _____

Phone: _____ Fax: _____ PCP _____

Address: _____ City: _____ Zip: _____

This form completed by: _____ Phone: _____

Patient information: (Please provide copy of patient demographics/face sheet)

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Phone: _____ Gender: ☐ Male ☐ Female

Patient Address: _____

City/State/Zip: _____

Reason for referral:

Service/Specialty Requested: _____ Diagnosis/ICD: _____

Physician Requested (if applicable): _____

Service Requested: ☐ Consultation ☐ Telehealth ☐ Second opinion ☐ Follow up ☐ Surgery

☐ Other (please specify): _____

Reason for Referral: _____

Documentation required: (Please provide the following with this form)

✔ Relevant clinical notes and test results, i.e., history & physical, MRI/CT/X-ray

✔ Copy of insurance card (front and back)

✔ Authorization information (if required)

Interpreter needed? ☐ Yes ☐ No Language: _____