

UW MEDICINE Referral Request

Thank you for referring your patient to UW Medicine. This form is to be completed by the outside referring provider or designee. For information about making referrals and/or to complete this form online and print it out go to: <http://uwmedicine.org/referrals>. A list of UW Medicine clinics and providers can also be accessed on the same web page. Note: UWP Physicians use UH2460.

| | | |
|--|---|-------------------------------|
| Patient Name (Last Name, First Name, Middle Initial) | | Date |
| Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Patient preferred language for healthcare communication | |
| Date of Birth | Patient Home Telephone | Patient Alternative Telephone |
| Patient Home Address | | |
| Patient insurance company and plan(s) | | |

Referral From:

| | | |
|---|------------------------|-----|
| Referring Provider Name (Last Name, First Name, Middle Initial) | | NPI |
| Referring Provider Contact Telephone | Referring Provider Fax | |
| Referring Provider Address | | |
| Patient's Primary Care Provider (Last Name, First Name, Middle Initial) | | |

Referral To:

| | |
|-----------------------|---|
| Specialty Clinic Name | Clinic Location |
| Provider Name | |
| Referral/Urgency | <input type="checkbox"/> Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Emergent: referring Provider must call consulting Provider for emergent referrals |

Reason for Referral:

| |
|---|
| <input type="checkbox"/> Consultation (<i>Diagnosis/Treatment/Surgical Opinion</i>) <input type="checkbox"/> Transfer of Care (<i>Indicate condition or problem the specialist is being asked to manage</i>) |
| Reason for request; include diagnosis: |
| Provider Signature |

PT.NO

NAME

DOB

UW Medicine

Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

UW MEDICINE REFERRAL REQUEST



U2394

WHITE – MEDICAL RECORD