

Referral Form

Referral is URGENT

Thank you for choosing to refer your patient to the John Muir Health/UCSF Health Berkeley Outpatient Center. To start the referral process, please complete this form and fax it directly to the clinic.

- Fax this form to **(510) 985-5202**.
- Send brief, pertinent medical records, including test results and imaging that support the consultation if available.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call **(510) 985-5200**.

Date: _____	From: _____
No. of pages: _____	Title: _____
To: Berkeley Outpatient Center	Phone: _____
Fax: (510) 985-5202	Fax: _____

PATIENT INFORMATION

Name of patient: _____ DOB: _____

Home phone: _____ Work phone Cell phone

Parent or caregiver: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance: _____

CONSULTING REQUEST INFORMATION

Diagnosis/ICD 10: _____

Name of MD (if known): _____ Specialty: _____

Reason for procedure: _____

Reason for visit: New patient Second opinion Transfer care Surgical procedure

Is authorization required? Yes No If yes, authorization number: _____

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

Primary care provider: _____ Phone: _____

Signature: _____

THIS FORM MUST BE COMPLETED AND FAXED TO BERKELEY OUTPATIENT CENTER PRIOR TO SCHEDULING

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.