Hospital Referral Form

Referring Provider Information

Provider Name: _____

Specialty: _____

Contact Number: _____

Email Address: _____

Patient Information

Name: _____

Date of Birth: _____

Gender: □ Male □ Female □ Other

Phone Number: _____

Address: _____

Medical Record Number: _____

Insurance Information

Insurance Provider: _____

Policy Number: _____

Group ID: _____

Medical History

Current Medications:

Known Allergies:

Past Medical History:

Recent Hospitalizations/Surgeries:

Family History:

Reason for Referral

Diagnosis: _____

Symptoms:

Urgency: □ Routine □ Urgent □ Emergency

Requested Services

□ Consultation □ Diagnostic Testing □ Surgery

□ Treatment □ Other: _____

Special Instructions

Attachments

□ Medical Records □ Lab Results □ Imaging Reports

□ Other Documents: _____

Referral Authorization

Referral Authorized By: _____

Signature: _____

Date: _____

Hospital Use Only

Received By: _____

Department Assigned: _____

Appointment Date/Time: _____

Confirmation Sent: □ Yes □ No