REFERRAL FORM

Thank you for choosing to refer your patient to us. To start the referral process, please complete this form and **fax it to (415) 353-4395**.

- Include brief, pertinent medical records, including test results and imaging, that support the consultation.
- Include patient's insurance card (both sides) and HMO authorization if required.

If you require additional assistance, please call 800-444-2559 and ask for either the UCSF practice or the Physician Liaison Service.

Date	From
No. of pages	Title
To UCSF practice	Phone
Fax	Fax

PATIENT INFORMATION

Name of patient

DOB

Home phone ❑ Work phone ❑ Cell phone

Parent or caregiver

Address

City State Zip

Insurance

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9/10

Name of UCSF MD (if known) Specialty

Reason for consultation

By providing the information requested and signing below, 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.

REFERRING PHYSICIAN INFORMATION

Referring MD Specialty

Phone Fax

Primary care provider Phone

Signature

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.

Source: medconnection.ucsfhealth.org | Form updated: October 2019