# REFERRAL FORM

UCSF Benioff Children's Hospitals

**Fax Oakland Referrals to 510-985-2202**

Preferred location: ☐ Brentwood ☐ Greenbrae ☐ Oakland ☐ San Ramon ☐ Walnut Creek ☐ Next available, any location ☐ Other: _____ ☐ URGENT

**Fax San Francisco Referrals to 415-353-4485**

Preferred location: ☐ Fremont ☐ Greenbrae ☐ Los Gatos ☐ Modesto ☐ Redwood Shores ☑ San Francisco ☐ San Mateo ☐ Santa Rosa ☐ Next available, any location ☐ Other: _____ ☐ URGENT

From: Date: No. of pages:

Phone: ( ) Fax: ( ) Referred to Provider (opt.):

Referred to Specialty/Clinic: Wellness Center for Youth with Chronic Conditions

## PATIENT INFORMATION

Patient First Name: Last Name:

DOB: Gender:

Home phone: ( ) ☐ Work phone *OR* ☐ Cell phone: ( )

Interpreter needed: ☐ Yes ☐ No Language:

Parent/Guardian: Relationship to Patient:

DOB: Email:

Address:

City: State: Zip:

## CONSULTATION REQUEST INFORMATION

Diagnosis: ICD-10:

Reason for referral:

Include brief pertinent medical records that support the consultation: ☐ Clinical notes ☐ Growth charts ☐ Imaging ☐ Labs

## REFERRING PHYSICIAN INFORMATION

Referring MD: Specialty:

Phone: ( ) Fax: ( )

Office Name:

Address: City: State: Zip:

Signature:

## PCP INFORMATION

PCP Name: Phone: ( )

## INSURANCE INFORMATION

☐ **Include copy of insurance card (both sides)**

Subscriber Name: DOB:

Health Plan: Member ID:

Group #: Authorization #:

Secondary Insurance, if any:

***By providing the information requested and signing above, 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.***

**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.

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