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