

**REFERRING CLINIC INFORMATION**

CLINIC: \_\_\_\_\_

PHONE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

FAX: \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_

DOB: \_\_\_\_\_

PHONE: \_\_\_\_\_

**PLAN OF CARE: \*Most specialties available for pediatrics**

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Oncology
<input type="checkbox"/> Allergy/Immunology/Asthma	<input type="checkbox"/> Rad Oncology
<input type="checkbox"/> Audio/Cognition	<input type="checkbox"/> PAP smear/ WWE
<input type="checkbox"/> Cardiology (No Surgery/Cath)	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> ECHO	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Holter	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Electrophysiology	<input type="checkbox"/> Pulmonology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Sleep Study
<input type="checkbox"/> Diabetes Self-Management Education	<input type="checkbox"/> Radiology
<input type="checkbox"/> Prediabetes Education	<input type="checkbox"/> Richardson Ultrasound Clinic
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Mammogram
<input type="checkbox"/> ENT (No Vertigo Cases)	<input type="checkbox"/> Del E Webb Xray Clinic
<input type="checkbox"/> GI (No hemorrhoids or screening scopes)	<input type="checkbox"/> Rheumatology
<input type="checkbox"/> Gynecology (No family planning)	<input type="checkbox"/> Rehabilitation Services
<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Nephrology	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Neurology (No EEGs)	<input type="checkbox"/> Speech/Swallow
<input type="checkbox"/> EMG	<input type="checkbox"/> Surgery
<input type="checkbox"/> Orthopedic and Sports Medicine	<input type="checkbox"/> General Surgery
<input type="checkbox"/> Ophth/Optometry (No surgeries)	<input type="checkbox"/> Vein/Vascular Surgery
<input type="checkbox"/> DM Retinopathy Screening-Last A1C: _____	<input type="checkbox"/> Vascular Surgery
	<input type="checkbox"/> Urology
	<input type="checkbox"/> Wound Care

**SUMMARY OF CARE AND REASON OF REFERRAL**

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**\*INCLUDE: MOST RECENT LABS/IMAGING & PERTINENT NOTES**