



Direct Referral Form

Patient Name: _____		Date: _____
DOB: _____		
Address: _____		SS# _____
Phone: () _____		<input type="checkbox"/> Healthy Families <input type="checkbox"/> Medi-Cal
Diagnosis: _____		ICD-9: _____
Referred To: * _____		Specialist Phone Number: () _____
Specialty: _____		Specialist Fax Number: () _____
Address: _____		Appointment Date:* _____
* Must refer to a specialist within network		*Initial consultation only
Clinical Reasons for Referral:		
THIS REFERRAL IS GOOD FOR 30 DAYS ONLY		
<ol style="list-style-type: none"> 1. Provide original form to Member to be presented to specialist. 2. Forward a copy to Requested Specialist. 3. Place a copy in Member's medical record. 4. Attach all necessary clinical information to this referral. 		
Requesting PCP:		
(Print PCP Name)		(Phone Number)
(PCP Signature)	(Date)	(Fax Number)