ARMC - OUTPATIENT REFERRAL FORM

(A completed form must be submitted with EACH referral.)

~DO NOT GIVE THIS FORM TO PATIENTS, PROVIDER USE ONLY. THANK YOU~

Send or Fax COMPLETED form to:

ARROWHEAD REGIONAL MEDICAL CENTER
Outpatient Referral Center, 1st Floor
400 North Pepper Avenue
Colton, CA 92324-1801
Phone: (909) 580-3171
FAX: (909) 580-1634

Circle One: Routine **URGENT**

1. PATIENT (PRINT) *** *ALL INFO* MUST *BE* COMPLETE AND LEGIBLE *TO PROCESS REFERRAL* ***

LAST	FIRST	MI	Male ____ Female ____
Address	**City**	**State**	**Zip**
Date of Birth	**Preferred Msg Phone #** ( )		
Soc Security # (write N/A if none exists)	**Insurance Type & ID# or Auth#** (write N/A if none exists)		

2. REFERRING PROVIDER INFORMATION –STAMP, LABEL OR PRINT

Required Information:	Physician / Organization Address Information
ORG/MED GRP	
PROVIDER	
Address	
City & Zip	
Phone Fax #	OFFICE #: ( ) FAX #: ( )

ARMC USE ONLY: Appt Status

DATE _____ TIME _____

If FAILED stamp here

or

R/S DATE _____ TIME _____

R/S DATE _____ TIME _____

REQUESTING PROVIDER SIGNATURE: _____ **DATE:** _____

3. REFERRAL (PRINT)

Specialty Clinic Requested (Circle ONE) Audiology Cardiology Dental Endocrine ENT GI Gynecology Neurology Neurosurgery Obstetrics Ophthalmology Oral Surgery Orthopedics Pediatric Subspecialty _____ Pulmonary Rheumatology Surgery Urology Wound Care Other _____

Diagnosis

Reason for Referral: (ATTACH SUPPORTING INFORMATION - H&P, labs, x-rays, MRIs, clinical progress notes, add'l tests/studies)

_____

_____

Service Requested: CONSULT ONLY _____ CONSULT & TX _____ CONSULT, TX, & FOLLOW-UP _____
(include F/U Auth# if applicable)

ARMC USE ONLY: UM COMMITTEE ACTION

( ) Approved ( ) Approved with Modifications ( ) Denied ( ) Pending ( ) Non Covered Benefit ( )Alternate Provider-Specify
Comments:

UMC Reviewer Signature _____ Date _____