



Colon and Rectal Surgery Referral to Mayo Clinic

Mayo Clinic Colon and Rectal Surgery Fax Referral Line • 507-284-1794

For other non-colorectal surgery referrals to Mayo Clinic, please call 1-800-533-1564 or go to www.mayoclinic.org/medicalprofs-rst/ and download a general referral form.

Referring Physician Information

REFERRING PHYSICIAN'S NAME			DATE (MO-DAY-YEAR)
OFFICE ADDRESS			UPIN #
CITY	STATE	ZIP	TELEPHONE
REPLY TO FAX #	NAME		

Patient Information

Patient Name	FIRST	MIDDLE INITIAL	LAST	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MAYO CLINIC #
ADDRESS					COUNTY
CITY		STATE	ZIP	DATE OF BIRTH (MO-DAY-YEAR)	
HOME TELEPHONE	WORK TELEPHONE	PARENT'S NAME (if minor)			
MAIDEN NAME			SPOUSE'S FIRST NAME		
DOES THE PATIENT HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DOES THE PATIENT BELONG TO AN HMO? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THE PATIENT ON MEDICAL ASSISTANCE (MEDICAID) <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS WORKERS' COMPENSATION OR LITIGATION INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PATIENT IS REFERRED FOR — <input type="checkbox"/> DISABILITY EVALUATION <input type="checkbox"/> TREATMENT/SURGERY			DATE OF INJURY (MO-DAY-YEAR)

Appointment Request

REQUESTED APPOINTMENT <input type="checkbox"/> EMERGENT <input type="checkbox"/> URGENT (<3 Days) <input type="checkbox"/> 4-14 DAYS <input type="checkbox"/> ROUTINE	DATE(S) PREFERRED FOR SCHEDULING PARAMETER TO
REASON FOR REFERRAL/SYMPTOMS/DIAGNOSIS (Please be specific and state area of involvement) —	

ONSET/DURATION	DATE(S) OF PREVIOUS SURGERIES/PREVIOUS TESTING
SPECIFIC CONSULTANT REQUESTED	

Mayo Clinic Reply

APPOINTMENT DATE (MO-DAY-YEAR)	DEPARTMENT / PHYSICIAN
REPORT LOCATION / TIME	
NOTES	

If the appointment scheduled is more than one week in the future, a letter of confirmation will be mailed to the patient.

Thank you for referring your patient to Mayo Clinic.

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