

**Referring Physician Information**

Referring Physician's Name			Date (Month DD, YYYY)	
Office Address		UPIN Number	NPI Number	
City	State	ZIP	Telephone	
Reply to Fax Number	Primary Care Physician		Contact Name	

**Patient Information**

Mayo Clinic Number	Patient Name (first, middle initial, last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address			County	
City	State	ZIP	Birth date (Month DD, YYYY)	
Home Telephone	Work Telephone	Parent's Name (if minor)		
Maiden Name		Spouse's First Name		
Does the patient need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language?				
Does the patient have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Company:		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 Worker's 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 <input type="checkbox"/> Motor vehicle accident		Injury Date (Month DD, YYYY)

**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)			
What specific problem is to be addressed?			
<input type="checkbox"/> Appointment only (e.g. routine eye appointment, follow up appointment) <input type="checkbox"/> Consult with option to manage (e.g. opinion and either management at Mayo or recommendation back on how to treat specific issue) <input type="checkbox"/> Management only (e.g. Treat specific problem with no expectation that you will be following this patient in the future nor desire any communication back to you)			
Onset/duration	Date(s) of previous surgeries/previous testing	Specialty requested	
If internal Medicine, <input type="checkbox"/> Full exam <input type="checkbox"/> Focused subspecialty consult	Specific consult requested		

**Mayo Clinic Reply**

Appointment date (Month DD, YYYY)	Department/Physician
Report location/time	Notes

*Thank you for referring your patient to Mayo Clinic.*

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