

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.