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Department of Orthopaedic Surgery

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UCDAVIS
HEALTH SYSTEM

SELF REFERRAL FORM

REFERRAL TYPE: ☐ ADULT ☐ PEDIATRICS TODAY'S DATE: _____

UCD MEDICAL RECORD NUMBER (if you have one):_____

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

PARENT/GUARDIAN: _____
LAST FIRST MIDDLE INITIAL

HOME PHONE: (_____) _____-_____ DAY TIME PHONE: (_____) _____-_____

D.O.B. _____/_____/_____ SS# _____-_____-_____ ☐MALE ☐FEMALE

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

REASON FOR REFERRAL _____

_____

DURATION OF SYMPTOMS_____ DATE OF INJURY _____
(if applicable)

PLEASE FAX A COPY OF YOUR INSURANCE CARD WITH THIS FORM

INSURANCE CARRIER: _____

INSURANCE ID #:_____INSURANCE GROUP #:_____

SUBSCRIBER FOR INSURANCE:_____
LAST FIRST MIDDLE INITIAL

DATE OF BIRTH FOR INSURANCE SUBSCRIBER: _____

PATIENT'S PRIMARY CARE PHYSICIAN:_____

☐ I am faxing the medical records pertaining to this referral with this form
☐ My doctors office will fax the medical records to UCD Orthopaedics under separate cover
☐ Other: _____

Thank you for choosing UCD Orthopaedics. Upon receipt of your self-referral and medical records, we will review the documentation and contact you at the number listed above regarding your appointment. This process typically takes 5-7 business days. If you would like to call us to determine the status of your referral, please call (916) 734-2700. Please do not use this self-referral form if you have a medical issue that requires immediate medical attention.