

Referral intake form

Please fax this completed form and checklist items to **916-703-6048**.

Number of pages: _____

Are you the patient's PCP: Yes No

Referring provider information

Referral Date: _____

Referring provider's name (Last, First, Degree):	Office contact name:	Office contact phone:
Office address:	Office phone:	Office fax:
City:	State:	Zip:
License number:	NPI number:	Primary specialty:

Patient information

Patient last name:	Patient first name:	Date of birth:	Gender:	SSN:
Address:		Home phone number (with area code):	Work/cell phone:	
City:		State:	Zip:	
If minor, name of parent/caregiver/guardian:		Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Language:	

Insurance/authorization information

Insurance/plan name:	Group number:	Prior authorization number:
Subscriber name/date of birth:	Subscriber member ID number:	Number of visits authorized/expiration date:
Secondary insurance/plan name:	Group number:	Prior authorization number:
Subscriber name/date of birth:	Subscriber member ID number:	Number of visits authorized/expiration date:

Consultation request information

Requested specialty and name of UC Davis provider (if known):	ICD-10 code(s):	ICD-10 code(s):	ICD-10 code(s):
Service requested: <input type="checkbox"/> Consultation <input type="checkbox"/> Second opinion <input type="checkbox"/> Surgery <input type="checkbox"/> Other:	Reason for referral:		

Worker's compensation

Work related: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," carrier name:		
Carrier address:		
Adjuster name:	Adjuster phone number:	Claim number:
Date of injury:	Employer name:	

This fax and any attachments thereto may contain private, confidential and privileged material for the sole use of the intended recipient. Any reviewing, copying, or distribution of this fax (or any attachments thereto) by anyone other than the intended recipient is strictly prohibited. If you are not the intended recipient, please contact the sender immediately and permanently destroy this fax and any attachments thereto.

Form completed by: _____ Phone: _____ Fax: _____ Email: _____