

**REFERRING CLINIC INFORMATION**

CLINIC: \_\_\_\_\_  
PHONE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_  
FAX: \_\_\_\_\_

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_  
LANGUAGE: \_\_\_\_\_

DOB: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**\*PEDIATRIC SERVICES AVAILABLE ONLY FOR THESE SPECIALTIES**

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> PAP Smear/WWE- Last Pap Dates: Circle One
<input type="checkbox"/> *Allergy/Immunology/Asthma	<input type="checkbox"/> Date: _____ Normal Abnormal
<input type="checkbox"/> *Audio/Cognition	<input type="checkbox"/> Date: _____ Normal Abnormal
<input type="checkbox"/> Cardiology (NO SURGERY/CATH)	<input type="checkbox"/> *Pediatrics
<input type="checkbox"/> Echo	<input type="checkbox"/> *Podiatry
<input type="checkbox"/> Holter	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> *Dermatology	<input type="checkbox"/> Pulmonology
<input type="checkbox"/> Diabetes Self-Management Education	<input type="checkbox"/> Sleep Study
<input type="checkbox"/> Prediabetes Education	<b>Radiology Services</b>
<input type="checkbox"/> General Surgery (REQUIRES IMAGING RESULTS)	<input type="checkbox"/> Del E Webb Xray Clinic
<input type="checkbox"/> *GI (NO HEMORRHOIDS, NO SCOPES)	<input type="checkbox"/> Screening Mammogram ONLY (ASYMPTOMATIC)
<input type="checkbox"/> *Gynecology (NO FAMILY PLANNING)	<input type="checkbox"/> *Richardson Ultrasound Clinic
<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Speech/Swallow
<input type="checkbox"/> Nephrology	<b>Rehabilitation Services</b>
<input type="checkbox"/> Neurology (NO EEGs)	<input type="checkbox"/> *Occupational Therapy
<input type="checkbox"/> EMG	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> *Orthopedic/Sports Medicine (REQUIRES IMAGING RES)	<input type="checkbox"/> *Rheumatology
<input type="checkbox"/> *Ophth/Optomery (NO SURGERIES)	<input type="checkbox"/> Urology
<input type="checkbox"/> DM Rethinopathy Screening- Last A1C: _____	<input type="checkbox"/> Wound

**\*REQUIRED TO INCLUDE SUMMARY OF CARE, REASON OF REFERRAL AND MOST RECENT PERTINENT NOTES, LABS & IMAGING**

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