UNM
Sandoval Regional
Medical Center, Inc.

Patient Name:
DOB:
MRN:

SRMC Urogynecology Clinic **Phone: (505) 994-7397** **Fax: (505) 994-7251**

External Referral / Consult Request Form

Instruction: The following information will be required for review of your referral. Please submit complete packet to the fax number above and allow up to 8 days for review.

- **Patient Demographics & Insurance Information** ☐
  - Include patient name, address, best contact number, insurance name & policy number
  - Prior Authorization information for specialty clinic visit (if necessary for patient's insurance, obtain for minimum of 3 visits)

- **Contact information for PCP <u>and</u> referring physician** ☐
  - Include address, phone and fax number

- **Consult Request / Referral /PA if required by Insurance** ☐
  - What condition or problem are you referring the patient for?

- **Recent Clinic/Progress Notes** ☐
  - Last visit, including what treatments have been done for the condition or problem
  - If patient has had prior urological or gynecological surgery, please send report(s)

- **Recent Diagnostic Imaging Studies/Reports** (up to 3 months) ☐
  - Patient should bring disk with any outside imaging studies/reports

- **Current Medication List** ☐

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Patient Appointment Status – For UNM Hospitals Use Only

☐ Appointment has been made with Dr. _____on _____ at _____am/pm

☐ Not able to schedule appointment due to:

__ Incomplete information for referral review
Comments:

__ Patient declined appointment

__ Recommend appointment with the following specialty _____.

We have forwarded your referral to the above at: _____

☐ Consultation via phone. Please call (888) UNM –PALS to discuss this referral.

Clinical Reviewer Signature: _____