



PROVIDER REFERRAL SERVICE
Phone: 612-365-0270

Request for Referral

To be used by providers and their staff

REFERRING PROVIDER INFORMATION

Referring Provider Name*
Referring Clinic Name*
Referring Clinic Address
City State Zip
Referring Clinic Phone Number*
Referring Clinic Fax Number
Referring Clinic Contact name (if different from referring provider) *
Referring Clinic Contract Direct Number (if different than main clinic number)

PATIENT INFORMATION

Patient First Name*
Patient Middle Name
Patient Last Name*
Patient Gender: Male Female Other
Patient Date of Birth (DOB)
Patient Address
City State Zip
Patient/Legal Guardian Name (if patient is a minor)
Patient Phone Number*

REQUESTED APPOINTMENT

Reason for Appointment (symptoms or diagnosis)
Specialty Requested*
Provider Requested (if any)

