

Patient Name: DOB: MRN:
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SRMC Bariatric Surgery Clinic Phone: (505) 994-7397 Fax: (505) 994-7252

**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** 
  - Please 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 and/or referring physician** 
  - Please include address, phone and fax number
  
- **Consult Request / Referral** 
  - What question do you need addressed by the specialist?
  
- **Recent Clinic/Progress Notes** 
  - Last 3 visits (if applicable)
  - Has patient had previous bariatric surgery? If yes, please obtain previous bariatric surgeon's name and contact information, if possible
  
- **Recent Diagnostic Imaging Studies/Reports** (up to 3 months) 
  - Radiology: CT, MRI, X-Ray, Ultrasound
  - Laboratory: CBC, UA, LFT, etc.
  - Other: EKG, ECHO, etc.
  
- **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: \_\_\_\_\_ Date: \_\_\_\_\_ Doc in EHR: Y / N