

Patient Name: DOB: MRN:

SRMC General 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
- **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)
- **Recent Diagnostic Reports** (up to 3 months)
 - Radiology: CT, MRI, X-Ray, Ultrasound
 - Laboratory: CBC, UA, LFT, etc.
 - Other: EKG, ECHO, etc.
- **Current Medication List**

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