

**NEW APPOINTMENT REFERRAL FORM**

* Please fax completed form to our central scheduling office at 402-955-6445
* Please send a copy of the front and back of the insurance card with this completed form
* Please send all relevant clinical documents (clinic notes, medication history, growth charts, labs, diagnostic reports, etc) related to this referral with this completed form
* **IF YOUR PATIENT NEEDS TO BE SEEN WITHIN 24 HOURS, PLEASE CALL THE CLINIC DIRECTLY**

For priority referrals, please indicate urgency below:

Urgent (within 1 week)  Routine (next available appointment)



**PATIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Last Name: | First: | | | Middle: |
| Date of Birth: | Sex: Male Female | | | |
| Address: City: State: Zip Code: | | | | |
| Parent(s)/Legal Guardian(s) Name: | | | | |
| Parent(s)/Legal Guardian(s) Phone Number(s): ( ) ( ) ( ) | | | | |
| Email: | | Insurance Plan: | | |
| Interpreter Needed: Yes Language: | | | Primary Care Physician Name: | |

**REFERRING PHYSICIAN INFORMATION**

|  |  |
| --- | --- |
| Referring Provider Name: | * Primary Care Provider  Other: |
| Provider NPI#: | Practice Address: |
| Fax Number: | Phone Number: |

**APPOINTMENT REQUEST**

|  |  |
| --- | --- |
| Reason for Visit:  New Patient  Second Opinion  Follow Up | Specialty: |
| Reason for Referral: | |
| Diagnosis: | |