Referral Request Form

Referral Guidelines

Thank you for choosing to refer your patient to us. We look forward to partnering with you in your patient's care. To start the referral process, please fax this form to the Seasons Center service to which you are referring your patient.

- Fax Number: (712) 262-3826
- Include brief pertinent medical records, including test results that support consultation

If you require additional assistance, please call (712) 262-2922 and ask for the nursing department.

Date:	From:
No. of pages:	Title:
Phone:	Fax:

Patient Information (*Please provide copy of patient demographics/face sheet):*

Last Name:	First Name:	MI:
DOB:	Phone:	Gender: □ Male □ Female
Patient's Address:		
City/State/Zip:		
Needs interpreter? □ Yes □ No	Language:	

Referring Provider Information

Referred by (MD):	Specialty:	PCP name:
Medical Group:		
Phone:	Fax:	Address:
City/State/Zip:		
This form completed by:		Phone:

Reason for Referral:

Diagnosis/ICD:

Service/Specialty Requested:

Physician Requested:

Reason for Referral:

Type of Service Requested: □ **Consultation Only** □ **Consultation & Stabilization** □ **Transfer**

DOCUMENTATION REQUIRED (*Please fax with this form):*

- Recent/relevant typed clinical notes/test results, I.e. history & physical, MRI/Ct/X-rays results
- Proof of insurance
- Authorization information (*if required)*