Western University of Health Sciences Patient Care Center

795 E. Second Street
Pomona, CA 91766-2007
Main: 909-706-3900

Interdepartmental Referral Form

Today's Date: _______________

Patient being referred to: (check one)

	Dental (x 3910)		Pediatrics (x 2565)
	Eye Care (x 3899)		Pharmacy/Anticoagulation (x 3730)
	Family Medicine (x 2565)		Physical Medicine & Rehabilitation (x 2565)
	Foot and Ankle (x 3877)		Western Diabetes Institute (x 3779)
	Osteopathic Manipulative Medicine (x 2565)		

Date of exam: _______________________

Patient Name: ____ **DOB:** ___________________________

Address: ____

Phone: ______________________ **Self-Pay or Insurance: (Policy#)** ___________________________

Diagnosis: ____

Reason for referral:

_____ Evaluation and management
_____ Co-management
_____ Second opinion
_____ Other

____
____
____

Priority:

- Stat (1-7 days)
- Urgent (8-14 days)
- Routine (15-30 days)

Referred by:

____

Report requested: No / Yes (send to) ____

Insurance Authorization # ___________________ Referral valid for _____ visits or _______ months

(Note: Dental services do not require insurance authorization for referral services)