PATIENT REQUEST FOR REFERRAL REVIEW

A request for primary care review. No clinical order or insurance approval is issued.

Request date

Who is making this request? (patient / someone else)

Patient name

Patient date of birth

Patient phone number (required if you are the patient)

Primary care practice or clinician

Specialty you want to discuss

Preferred specialist or office (optional)

What would you like your primary care team to review?

Specialist appointment date (if already scheduled)

Your name as the representative (if requesting for someone else)

Your relationship to the patient (if requesting for someone else)

Your phone number as the representative (if requesting for someone else)

Give this request to your primary care team using its accepted process.

Representatives: ask the practice what it needs to confirm your role before sharing information.

This form does not establish representative authority or authorize a release of medical records.

Downloading this form does not send it to a clinician or create a tracked office request.