Project Access

Orange Flag Building 104 S. Freya Street, Suite 114, Spokane, WA 99202 Phone:(509) 532-8877 Fax: (509) 532-1375

Physician Request for Referral/Consultation

Patient Name: ______________________ DOB: __________ Gender: M F

Interpreter Needed: Y N Language: ____________________ Phone: ____________

Date of Referral: ______________ Referring Provider: ________________________

Specialty Requested: ______________________ Diagnosis Code (ICD-9): ____________

Working Diagnosis: ____

Reason for Referral (Symptoms): ______________________________________

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Date of Onset of Current Problem/Symptoms: ______________________________

Exam/Treatment to Date (please attach pertinent medical records): ____________

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Diagnostic Testing Completed (please attach reports):

- ☐ Lab Report ☐ Pathology Report ☐ Imaging Report
- ☐ Other: ______________ ☐ Other: ______________

Co-morbidities: ☐ Alcoholic ☐ Smokes ☐ Diabetic ☐ Cardiac Disease

☐ Consult Only ☐ Evaluate and Treat ☐ Evaluate/Treat/Surgery if indicated

What specific questions do you want answered by the consultant? ______________

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Who do you want to manage the patient's medications? ☐ Primary Care ☐ Specialist

Send information to: ____

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______________________________ ______________

Signature of Referring Provider Date of Referral

Treatment/Follow-up Recommendations : ______________________________

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______________________________ ______________

Signature of Project Access Provider Date

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Name (Please Print)

Please fax this form to Project Access at (509) 532-1375

Appendix E