



Valleywise Health

2601 E. ROOSEVELT · PHOENIX, ARIZONA 85008

8088 W. WHITNEY · PEORIA, AZ 85345

SPECIALTY REFERRAL



DT345

Patient Identifier

Place Patient Label Here

Fax to: 602-655-9000 or email [ReferralAdmin@valleywisehealth.org](mailto:ReferralAdmin@valleywisehealth.org)  Routine  Urgent

Date of referral:		Practice Name:	
Referring Provider:		PCP <input type="checkbox"/> same as referring	
Referring Provider Signature:			
Address:			
Practice Referral Contact Person:			
Practice Contact Phone#:		Practice Contact Fax#:	
<b>Patient Demographic Information:</b>			
Patient Name:		DOB:	
Parent/Guardian Name:		Relationship:	
Parent/Guardian Phone#:		Alternate Phone#: <input type="checkbox"/> none	
Patient Address:			
Patient's Insurance		Insurance ID#:	
		Group:	
Authorization Number:		#Visits:	<input type="checkbox"/> Requested but pending <input type="checkbox"/> No Authorization required
<b>Adult Medical Specialty Requested:</b>			<b>Peoria Services</b>
<input type="checkbox"/> Audiology	<input type="checkbox"/> Hand	<input type="checkbox"/> Podiatry	<input type="checkbox"/> Ophthalmology/Optometry
<input type="checkbox"/> Breast	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Surgery (General)
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Rehab	<input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT
<input type="checkbox"/> Dental	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Renal	<input type="checkbox"/> Urology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Oncology/Hematology	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Vascular
<input type="checkbox"/> ENT	<input type="checkbox"/> Ortho	<input type="checkbox"/> Endoscopy	<input type="checkbox"/> OB/GYN (Fax to 602-344-5596)
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Plastics		(Fax to 602-655-9560) (PH: 602-655-2334)
<b>Clinical Information:</b>			
Reason for referral:			
Diagnosis:		Dx Code:	
In order to assist us in providing the best care for your patient, please include copies of the following critical clinical information as well as results of any diagnostic testing that may have already been done and let us know what is pending.			
Recent Progress notes:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Problem List:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Medication List:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Current Immunizations record:	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Relevant Radiology reports & Imaging: (CTs, MRIs, X-rays, Recent CXR needed for Cardiology)	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	<input type="checkbox"/> Pending
Recent Pertinent Lab results	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	<input type="checkbox"/> Pending
Notes from previous specialists if not MIHS	<input type="checkbox"/> Attached	<input type="checkbox"/> None Available	
Other pertinent diagnostic reports (i.e. EEG, EKG)	<input type="checkbox"/> Attached	<input type="checkbox"/> None available	<input type="checkbox"/> Pending
Other	<input type="checkbox"/> Attached	<input type="checkbox"/> None available	<input type="checkbox"/> Pending

Valleywise Health Comprehensive Health Center  
2525 E Roosevelt Street Phoenix AZ, 85008

Scheduling #: 602-344-1015; Email: [ReferralAdmin@ValleywiseHealth.org](mailto:ReferralAdmin@ValleywiseHealth.org); Fax# for Referrals: 602-655-9000