



2525 E Roosevelt Street
Phoenix AZ 85008

PHOENIX ADULT SPECIALTY REFERRAL

Fax: 602-655-9000

email: 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#:	
Patient Demographic Information			
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
Adult Medical Specialty at Phoenix Comprehensive Health Center			
<input type="checkbox"/> Audiology	<input type="checkbox"/> Hand	<input type="checkbox"/> Plastics	<input type="checkbox"/> Ophthalmology/Optometry
<input type="checkbox"/> Breast	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Podiatry	<input type="checkbox"/> General Surgery
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT
<input type="checkbox"/> Dental	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Rehab	<input type="checkbox"/> Urology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Oncology/Hematology	<input type="checkbox"/> Renal	<input type="checkbox"/> Vascular (Provide bi-lateral Venus Duplex US)
<input type="checkbox"/> ENT	<input type="checkbox"/> Ortho	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> OB/GYN (Fax to 602-655-9136)
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/>		<input type="checkbox"/> Endoscopy (Fax to 602-655-9561)
Clinical Information:			
Reason for referral:			
Diagnosis:		Dx Code:	
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"/> Non-Available	
Current Problem List:	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	
Current Medication List:	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	
Relevant Radiology reports & Imaging: (CTs, MRIs, X-rays, Recent CXR needed for Cardiology)	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	<input type="checkbox"/> Pending
Recent Pertinent Lab results	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	<input type="checkbox"/> Pending
Notes from previous specialists if not Valleywise	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	
Other pertinent diagnostic reports (i.e., EEG, EKG)	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	<input type="checkbox"/> Pending
Other	<input type="checkbox"/> Attached	<input type="checkbox"/> Non-Available	<input type="checkbox"/> Pending

Valleywise Health Comprehensive Health Center

Scheduling #: 602-344-1015; Email: ReferralAdmin@ValleywiseHealth.org; Fax# for Referrals: 602-655-9000