Thank you for Choosing SLU*Care* Physicians Group.
To expedite your referral request in a timely manner please FULLY complete this form.

**SLU*Care* CENTRAL REFERRAL MANAGEMENT**
Phone (314) 977-4440
Fax **(314) 977-8299**

## REFERRAL REQUEST FORM

Patient Name: ______________________________ Date of Birth: ________ Female __ or Male __

Address: ______________________________

City: ______________ State: ________ Zip: ________ Phone: ______________

Social Security Number: ______________ Translator needed: Yes __ No __ Language: ______________

Insurance: Yes __ No __ Insurance Type: ______________ Insurance ID #: ______________

Subscriber Name: ______________ Subscriber D.O.B.: ________ Group #: ______________

Guarantor Name: ______________ Relation: ________ D.O.B.: ________ Phone: ______________

Primary Care Physician Full Name: ______________ Phone: ________ Fax: ______________

## REFERRAL/PHYSICIAN INFORMATION

*To ensure appointments are scheduled in a timely manner, please complete all fields.*

Referring Provider Full Name: ______________________________ Phone: ______________

Address: ______________________________ Fax: ______________

City: ______________ State: ________ Zip: ________ Fax: ______________

Clinical Reason for Referral with Diagnosis Code (ICD 10 Code): ______________ Urgent Appointment ☐ First Available ☐

Referring to Department and/or Doctor: ______________________________

Today's Date: ________ Clinical Staff Name and Number: ______________________________

**Please include all records, labs and imaging.**

5/21/20