

La Crosse, Holmen and Onalaska* REFERRAL REQUEST FORM

(for appointments at Mayo Clinic, Gundersen Lutheran or other non-FSH sites)

*Clinics other than La Crosse, Holmen, and Onalaska are to use this form for Health Tradition patients and Fax it to HT (608)-781-9654

Please complete both pages, including the record release checklist and **fax form to 608-392-9814, attn: FSH Call Center, Patient Referral Office**. Please indicate what services you are requesting from the Call Center for this referral. **Incomplete information will be sent back to the referring provider resulting in a delay of the process and could result in denial of the appointment. Absolute mandatory fields are indicated with ***. Call 608-392-9816 with questions.

REFERRING PROVIDER INFORMATION (PLEASE PRINT)

*Referring Provider Name	Name of Person Completing this Form	Department Phone for Questions	Patient's FSH Clinic Number
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PATIENT INFORMATION (do not use label)

INSURANCE INFORMATION

*Patient Name (First, Middle Initial, Last)		*Name of Insurance (Including Medicare and Medicaid)			
Maiden Name or Previous Names Used (required if female)		*Individual ID Number for Insurance			
Address		*Please List Any Other Insurance Information Available			
City, State, Zip		Referral is for <input type="checkbox"/> Disability Evaluation <input type="checkbox"/> Treatment/Surgery <input type="checkbox"/> MVA <input type="checkbox"/> Other Is Litigation Involved? <input type="checkbox"/> Y <input type="checkbox"/> N Date of Injury if Applicable			
*Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Preferred Phone #	Alternate Phone #	Is it OK to Leave a Detailed Message? <input type="checkbox"/> Y <input type="checkbox"/> N	Interpreter Needed? <input type="checkbox"/> Y <input type="checkbox"/> N What Language?

APPOINTMENT REQUEST INFORMATION

*Location/Facility Name Requested	Department Requested	Specific consultant requested	*Appointment Type <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent (<3 Days) <input type="checkbox"/> 4-14 Days <input type="checkbox"/> Routine
*Indicate why patient needs cannot be met at Franciscan Skemp Healthcare or at any other in-network facility (Mayo is out-of-network)			
List date(s) and name(s) of specialist(s) who have previously evaluated patient for this diagnosis/condition			
*Chief Complaint (must include diagnosis) Requiring Referral			
*Date that Referral Letter was dictated (STAT Note, Line 21)			
This letter must include 1) reason for referral, 2) symptoms, 3) onset, 4) duration, 5) diagnosis, 6) dates and provider names of previous procedures, surgeries and testing applicable to this referral. Referrals with no dictated letters will not be processed			
*What assistance would you like from the Patient Referral Coordinators regarding this referral (check all that apply)? <input type="checkbox"/> Fax form to Health Tradition <input type="checkbox"/> Make appointment <input type="checkbox"/> Obtain records and forward records to referral appointment <input type="checkbox"/> Other (please explain) <input type="checkbox"/> Nothing			
If appt has already been made what is the date of that appt?			
List all applicable tests, radiology services, diagnostic outpatient testing and out patient procedures that cannot be done in-network. Recent Clinic Note or Letter with this information may be referenced.			
**All applicable tests, radiology services, diagnostic outpatient testing and outpatient procedures are expected to be done in-network before to this consultation visit and either sent with the patient or forwarded to the consulting physician in advance. Health Tradition Health Plan requires prior authorization and approval for covered services by the plan before any services are received by a member from an out-of-network provider. Mayo Clinic is considered an out-of-network provider.			

Patient Name _____ Date of Birth _____ Date of Request _____

FSH RECORD RELEASE CHECKLIST

Please select the items (including the dates of service) you would like to send with the patient for the appointment. The Patient Referral Office will compile the information for the patient to carry with them to the appointment or send it in advance. Pathology slides will be sent via courier.

***FSH Provider referral letter or complete recent note is REQUIRED (Indicate it is a referral letter and the work type is 21 stat). Be sure to include: 1) reason for referral, 2) symptoms, 3) onset, 4) duration, 5) diagnosis, 6) dates and provider names of previous procedures, surgeries and testing applicable to this referral.**

	Items Requested	Date(s) of Service
X	Referral Letter or Recent Summary Note*	
Radiology		
	CT Films and Reports	
	MRA Films and Reports	
	MRI Films and Reports	
	Nuclear Medicine Films	
	Radiology Films and Reports	
	Ultrasound Films and Reports	
	Mammography Films and Reports	
Pathology		
	Path Slides and Reports	
Cardiology		
	Cath Films and Reports	
	Echo Films	
	GXT Tapes	
Pt Referral (obtained from Clinician Portal)		
	Clinic Notes (dates and provider/dictator)	
	Consult Notes	
	Discharge Summary	
	EMG Report	
	History and Physical	
	Lab Reports	
	Operative Report	
	Path Report	
	EKG Reports	
	EMG	
	Evoked Potentials <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Somatosensory	

	Items Requested	Date(s) of Service
Health Information Management		
	Audiograms	
	Colposcopy Record	
	Dermatology Reports (specify)	
	EEG	
	Growth Charts	
	Holter Reports	
	Immunization Records	
	Nursing Flow Sheet (height, weight hx)	
	Pap Smear Results	
	Pediaforms	
	PFT Reports	
	Phone Notes	
	Photographs	
	Prenatal Record	
	<input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech Tx Records	
	Sleep Study Report	
	Uroflow Record	
	Visual Field Report	
Other		