

La Crosse, Holmen and Onalaska REFERRAL REQUEST FORM

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

1. Complete both pages, including the record release checklist and **fax completed form to 608-392-9814.**
2. Absolute mandatory fields are indicated with *. **Incomplete information will be sent back to the referring provider resulting in a delay of service and could result in referral denial.**
3. Indicate what services you are requesting from the Call Center for this referral.
4. **Call 608-392-9816 with questions.**
5. Fax to HT directly at 608-781-9654 ONLY if you want NO ASSISTANCE from the Center.

REFERRING PROVIDER INFORMATION (PLEASE PRINT)

*Referring Provider Name	Name of Person Completing this Form	Department Phone for Questions	Patient's Medical Record Number
---------------------------------	-------------------------------------	--------------------------------	---------------------------------

PATIENT INFORMATION (do not use label)

INSURANCE INFORMATION

*Patient Name (First, Middle Initial, Last)		* Insurance Plan Name (Including Medicare and Medicaid)			
Maiden Name or Previous Names Used (required if female)		*Individual ID Number for Insurance			
Address		*List Any Other Insurance Information Available			
City, State, Zip		*Reason for Non-Mayo Referral (if applicable)			
*Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Preferred Phone #	Best Time to Call	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 Requested	Department Requested	Subspecialty Requested	Specific consultant requested
*Appointment Timeline <input type="checkbox"/> Emergent <input type="checkbox"/> Urgent (<3 Days) <input type="checkbox"/> 4-14 Days <input type="checkbox"/> Routine <input type="checkbox"/> Other _____	*Appointment Type <input type="checkbox"/> Consult <input type="checkbox"/> Surgery <input type="checkbox"/> Diagnostic Test <input type="checkbox"/> Other _____	*What services are you requesting from the Call Center Patient Referral Coordinators? (check all that apply) <input type="checkbox"/> Nothing <input type="checkbox"/> Fax form to Health Tradition <input type="checkbox"/> Make appointment, obtain records and forward to referral appointment <input type="checkbox"/> Other (please explain)	
*Indicate why patient needs <u>cannot</u> be met at MCHS Franciscan Healthcare			
*In the last 12-24 months, what specialist(s) have been consulted or evaluated this patient for this diagnosis/condition			
*Chief Complaint (<u>must include diagnosis</u>) Requiring Referral and ICD-9 Code			
*Date that Summary Dictation was completed (STAT Note, Line 21)			
This dictation 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 dictation available for review will not be processed			
If appt has already been made what is the date of that appt?			
List all expected tests, radiology services, diagnostic outpatient testing and outpatient procedures that cannot be done in-network. Recent clinic note or letter with this information may be referenced if available in the EMR.			

All applicable tests, radiology services, diagnostic outpatient testing and outpatient procedures are expected to be done in-network before this consultation visit. 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.

***FH Provider referral letter or complete recent summary 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		