UNM Sandoval Regional Medical Center, Inc.

Patient Name:
DOB:
MRN:

SRMC Neurosurgery Clinic Phone: (505) 994-7336 Fax: (505) 994-7256

External Referral / Consult Request Form

Instruction: The following information will be required for review of your referral. Please submit complete packet to the fax number above and allow up to 8 days for review.

- **Patient Demographics & Insurance Information** ☐
  - Please include patient name, address, best contact number, insurance name & policy number
- **Contact information for PCP <u>and/or</u> referring physician** ☐
  - Please include address, phone and fax number
- **Consult Request / Referral** ☐
  - What question do you need addressed by the specialist?
- **Recent Clinic/Progress Notes** ☐
  - Last 3 visits (if applicable)
- **Recent Diagnostic Reports** - Must be completed within last 12 months ☐
  - Diagnostic testing is required for all patients prior to referral. MRI is preferred.
  - If you have questions regarding this, please call and speak to a nurse
- **Current Medication List** ☐

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Patient Appointment Status – For UNM Hospitals Use Only

☐ Appointment has been made with Dr. _____on _____ at _____am/pm

☐ Not able to schedule appointment due to:

__ Incomplete information for referral review
Comments:

__ Patient declined appointment

__ Recommend appointment with the following specialty _____.

We have forwarded your referral to the above at: _____

☐ Consultation via phone. Please call (888) UNM –PALS to discuss this referral.

Clinical Reviewer Signature: _____ Date: _____ Doc in EHR: Y / N