# Project Access San Diego Patient Referral Form

*Referring clinic:* Once completed, please **fax to (858) 560-0179** with the Patient Enrollment Form and pertinent medical records attached.

## Patient Information

| Name | | DOB | |
|---|---|---|---|
| Gender | | Preferred Language | |
| Phone | | Other Phone | |
| Address | | | |
| City, State, Zip | | | |

Diagnosis (include both description and ICD-9 code):

Specialty Service(s) and Procedure(s) Requested (include CPT code):

Level of Urgency (Applications will be reviewed within this time period):
Non-Routine (3-5 days) Routine (2-3 weeks)

## Primary Care Information

| Provider Name | | | |
|---|---|---|---|
| Referral Coordinator Name | | | |
| Clinic Name | | | |
| Address | | | |
| City, State, Zip | | | |
| Office Phone | | Office Fax | |
| Provider Signature | | Date | |
| Direct Phone Number for Specialist to Contact Physician | | | |

Attached:
☐ Problem List ☐ Medical History ☐ Labs ☐ Radio. Report ☐ Consults
☐ Progress Note
☐ Other_______________________________________________