Patient Name:

DOB:

MRN:

SRMC Bariatric Surgery Clinic Phone: (505) 994-7397 Fax: (505) 994-7252

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
- Prior Authorization information for specialty clinic visit (if necessary for patientøs insurance, obtain for minimum of 3 visits)

Contact information for PCP and/or 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)
- Has patient had previous bariatric surgery? If yes, please obtain previous bariatric surgeonøs name and contact information, if possible

Recent Diagnostic Imaging Studies/Reports (up to 3 months) ☐
- Radiology: CT, MRI, X-Ray, Ultrasound
- Laboratory: CBC, UA, LFT, etc.
- Other: EKG, ECHO, etc.

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