**MyClinicalService Physician Referral Form**

| **Patient Information** | | |
| --- | --- | --- |
| Patient Name  **Cecilia** | | Patient Barcode Sticker |
| DOB, Medical Record Number (MRN)  ….………… …………………… …….. | |
| **Requesting Provider** | | |
| Assigned Provider/Practice Name:  Jane Ferreiro, MD / MyClinicalService | | Specialty/Department:  Internal Medicine |
| Address:  900 23rd St NW  Washington, DC 20037 | | Phone: (202) 555-1212  Facsimile #: (202) 555-1212 |
| **Consultant Provider** | | |
| Provider’s Name:  to be assigned | | Specialty/Department:  Molecular Science/M1 Training |
| Address:  2300 I St NW, Suite 201  Washington, DC 20052 | | Phone: (202) 555-1212  Facsimile #: (202) 555-1212 |
| **Referral Information** | | |
| Authorization No: | Authorization Type: | |
| Reason for Referral: **Treatment ineffective** | | |
| Diagnosis: **E11.9 – Type II Diabetes** | | |
| Clinical Notes: Patient was prescribed Metformin at previous office visit after positive A1C test and Type 2 D diagnosis. Patient continues to experience frequent urination and is now experiencing unexpected weight loss. Recommend insulin panel.  Please consult with the family and send a copy of the final report back to this office. Thanks. | | |
| Procedures: Variant Interpretation – Molecular Impact Characterization | | |
| Visits Allowed: 3 | | |
| Unit Type: V (VISIT) | | |
| Referral is Valid Until: 12/28/2024 | | |
| Notes: Patient must arrive 30 minutes early, with a picture ID, Insurance card and have a copy of this referral. If the referred patient is a minor and anyone other than the child’s parents are escorting the child to the appointment, a letter of consent by the parent is needed. Please bring a list of medications the patient is taking with you to this appointment (including over the counter). | | |
| **Please send the final report by Fax to: (202) 555-1212** | | |
| Signature:    Ferreiro, Jane, MD on 12/29/2024 at 9:32 AM EDT | | |