Volunteer HEALTH CARE

Need Assistance?
Physician Helpline: 866-555-1212

Referral Request Form

(Items with ** are required for processing)

Fax To: 865-321-1234 or Submit online

Radiology Referrals / Orders: Use Form: https://volunteerhealthcare.org/imaging

Patient Information

Reason for Referral

If Medical Records Cover Sheet is included, Patient information can be left blank	Priority: Routine ☒ **Medically Urgent** ☐
Name *(First, Middle, Last)*** Kate Beck Sex: ☐ Male ☒ Female	**If Medically Urgent**, please describe:
Date of Birth** 11/25/1999	Diagnosis/ICD 10** J30.9
Phone # ** (630) 617-5123 Secondary Contact #	Clinic / Specialty Requested** Food Allergy Testing
Address** 493 Waveland Ave	Physician Requested Dr. Joe Gupta Location Requested Chicago, IL
City** Chicago Zip Code** 60613 State IL	If Requested Physician is Unavailable, Can Patient be seen by another provider? ■ Yes ☐ No ☐ Contact Referring Provider
Interpreter Needed? Yes ☐ No ■ Preferred Language:	☐ Consultation ☐ 2nd Opinion ■ Procedure ☐ Other

Referring Provider Information

Referring Provider Name** Dr. Mary Fitzgerald		PCP Name
Practice Name** Spectrum Medical Group		
Office Address** 399 Main Street		City** Chicago
State** IL	ZIP Code** 60606	NPI Number
Phone** (312) 789-5555	Fax** (312) 789-1222	Provider Specialty

Documentation Requested

☐ Relevant Clinical Notes **(History & Physical, Imaging and Lab results)**

☐ Copy of Insurance Card ☐ Insurance Authorization Information (If required)

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