

REFERRAL FORM

500-0611i (Rev. 11/24)

Fax Oakland Referrals to 510-985-2202	Fax San Francisco Referrals to 415-353-4485
Preferred location: Brentwood Greenbrae Oakland	Preferred location: Fremont Greenbrae Los Gatos
□ San Ramon □ Walnut Creek □ Next available, any location	□ Modesto □ Redwood Shores □ San Francisco
□ Other:	🗆 San Mateo 🛛 Santa Rosa 🗌 Stockton
	□ Next available, any location □ Other: □ URGENT
From:	Date: No. of pages:
Phone: () Fax: ()	Referred to Provider (opt.):
Referred to Specialty/Clinic:	
PATIENT INFORMATION	
Patient First Name:	Last Name:
DOB:	Gender:
Home phone: ()	□ Work phone <i>OR</i> □ Cell phone: ()
Interpreter needed: Yes No	Language:
Parent/Guardian:	Relationship to Patient:
DOB:	Email:
Address:	
City:	State: Zip:
CONSULTATION REQUEST INFORMATION	
Diagnosis:	ICD-10:
Reason for referral:	
Include brief pertinent medical records that support the consultation	: 🗌 Clinical notes 🛛 Growth charts 📄 Imaging 🗌 Labs
REFERRING PHYSICIAN INFORMATION	
Referring MD:	Specialty:
Phone: ()	Fax: ()
Office Name:	
Address:	City: State: Zip:
Signature:	
PCP INFORMATION	
PCP Name:	Phone: ()
INSURANCE INFORMATION	
\Box Include copy of insurance card (both sides)	
Subscriber Name:	DOB:
Health Plan:	Member ID:
Group #:	Authorization #:
Secondary Insurance, if any:	
By providing the information requested and signing above, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan. NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.	