Referral Phone (877) 333-0122| Referral Fax (800) 641-9002

REFERRAL REQUEST FORM

REFERRING PROVIDER:	
Referring Provider Name:	Patient PCP:
Clinic:	Clinic Contact:
Phone:	Fax:
Email:	☐This is a self-referral.

PATIENT INFORMATION (All information must be filled out to process this referral.)		
Name (first/middle/last):		☐Female ☐Male
Date of Birth (mo/day/yr): / /	Does the patient need interpreter? ☐Yes ☐No	If yes, what language:
Address:	City/State/Zip:	
Phone:	Alternate Phone:	
Primary Insurance:	Secondary Insurance:	
Primary ID:	Secondary ID:	
Primary Group #:	Secondary Group #:	
Patient's Guarantor:		

REFERRAL DETAILS (All information must be filled out to process this referral.)	
Name of Specific VM Provider Requested:	☐Or schedule with first available provider.
Patient is being referred for (please be specific):	
Diagnosis code (if available):	

FAX THIS FORM ALONG WITH THE FOLLOWING DOCUMENTS TO: (800)641-9002
✓ H&P/Referral Dictation ✓ Medication/Allergy List ✓ Lab Results ✓ Pathology Reports ✓ Diagnostic studies (CT, MRI, US, XRAY, etc.)

Thank you for referring your patient to Virginia Mason.

You will receive confirmation once this referral is received.