UMassMemorial Health Care

Physician Referral Services - Intake Form
Telephone: 800-431-5151 / 508-856-5656 Fax: 508-334-7616 Today's Date:

PCP / Referring MD:
Phone:
Fax:
Contact Name:

Priority of Request: (check one below)

☐ Urgent [24-48 hrs.] ***Medical Reason for Urgency**
***Requires clinical notes & recent imaging**
☐ ASAP [7-10 days]
☐ Non-Urgent [30 days]
☐ 2nd Opinion
☐ Consult

Interpreter Needed: Y N
Language:

Specialty Clinic:

Preferred Provider:

Preferred Location:

Information Below is required for EPIC.

PATIENT:
DOB: **SEX:**
ADDRESS:
EMAIL:
PHONE: (H) **(C)**
RACE:
ETHNICITY:
PRIMARY INSURANCE:
POLICY NUMBER:
GUARANTOR (NAME/DOB):
(UNDER 18)
SECONDARY INSURANCE:
POLICY NUMBER:
GUARANTOR (NAME/DOB):
(UNDER 18)
SUBSCRIBER (NAME/DOB):

****Note: To expedite scheduling appointments, please make sure the following information is sent to PRS.**

- Complete and fax any clinical notes, labs, x-rays, MRI's, Cat Scans.
- Questionnaires for Mammography, Cat Scans, Nuclear Med must be filled out and faxed with referrals.

Diagnosis: **ICD 10 CODE:**

Prior Authorization:
Dates: **Contact Name:**
Number of visit: **Telephone:**

***Required for MRI's and CT Scan's**

MVA / Worker's Comp: **Date of Injury:**
Claim Number:
Insurance Co:
Address: **Telephone:**