

Consultation	/ Keterral Form
SCVHHS providers i	olease fill shaded areas
Date:	
Fax Information	
# of Pages includin	g form:
This fax is from:	

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HEALTH AND HOSPITAL SYSTEM	Telephone:			
Last Name:		First Name:		MI:
Address		City:	State:	7in Code:
Telephone:		Date of Birth:	Sex:	□ M □ F
Primary Langua	ge:		Translator Needed?	□Y □N
Referring Provide	PF:	Sign	ature:	
VMC Dector#:		Der	oarlment:	
Referring Clinic/		-7,		
Primary Care:		Children's Shetter Silver Creek	□ Emergency Departmer □ East Valley □ Fair O □ South Valley □ VHC □ OPD □ VHC	aks Other:
Other:		Fax:	Pager:	
r external clinic or agen	cy:			
Address:		Cify:	State:	_Zip Code:
Consultant Name	9;	Consultant :	pecially/Department:	
Please Check Or	ne: 🗆 ROUTINE	OR	URGENT	
Insurance Plan:		# of visits request	ent consultations should be requested: CCS Referral in	ndicated? 🔲 Y 🔲 N
Working Dx Reason for Reau	est. Diagnosis and	l Relevant Clinical Infor	ICD-9 co	de
			TIGHOTI (Allocitidity necessity re	ports, tests, etc.)
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☐ PROCEDURE (ONLY:			
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GUIDELINES D		(CHECK WHEN COMPLETE) APPOINTMENT DATA	DEDO	DT DATA
Guidelines m		Appointment Kept (se		RT DATA of Report:
\square Guidelines no	ot met	Appointment Not Ker	ot Re <u>po</u>	rt Faxed by SS to:
PCP Notific	ed 🖺	Appointment Resche		PCP

D	FOR REFERRAL CENTER USE O	NLY (CHECK WHEN COMPLETE)
I S P O S I T	GUIDELINES DATA Guidelines met Guidelines not met PCP Notified AUTHORIZATION DATA Authorization Obtained Reference #	APPOINTMENT DATA Appointment Kept (see below) Appointment Not Kept Appointment Rescheduled Appt Date: Appt. Time:
1 0 N \$	Number of Visits: Authorization Denied PCP Notified of Denial	SPECIAL DATA CCS Referral Sent DISPOSITION - PERMANENT MEDICAL RECORD

Date:
Authorizing Agency
Date:
PLEASE FAX THIS FORM
AND PROGRESS NOTE TO-

(408) 885-3535