Kaweah Health
Cardiothoracic Surgery Clinic

NEW PATIENT REFERRAL

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REFERRING OFFICE INFORMATION

Referring Physician: _____ Date of Referral: _____

Contact Person: _____ Phone #: _____ Fax #: _____

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ SSN: _____

Home #: _____ Cell #: _____ Email: _____

Patient prefers to be contacted by: ❒ Home # ❒ Cell # ❒ Email

Employer: _____ Employer Phone #: _____

Why is the patient being referred?
❒ CONSULTATION ❒ SECOND OPINION ❒ CONSULTATION & TREATMENT

PATIENT INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Is an auth required? **Codes: Consult 99243 or 99244 Office Visit 99213 or 99214** *(request for at least 3 visits)*
❒ YES (Auth #: _____) ❒ NO (please confirm if needed for visit) ❒ NONE REQUIRED

Is a referral required from patient's insurance company?
❒ YES (Referral #: _____) ❒ NO (please confirm if needed for visit) ❒ NONE REQUIRED

REQUIRED DOCUMENTS *(Please include the following along with this referral form)*

❒ Prior Authorization ❒ Insurance Referral *(if required)* ❒ Recent H & P
❒ All test performed to diagnose the patient's condition:
❒ All related CTs ❒ Heart Cath ❒ X-Rays ❒ All related MRIs ❒All related Labs ❒ PFTs
❒ PET/CT Scans ❒ Angiogram ❒ Any other studies or test related to patient's diagnosis

Thank you for considering Kaweah Health Cardiothoracic Surgery Clinic for the care of your patient. To avoid delays in scheduling, please ensure that all of the required documents are included with this referral.

REMINDER: IF ANY OF THE ABOVE INFORMATION IS NOT INCLUDED WITH THIS REFERRAL, IT MAY CAUSE A DELAY IN THE PATIENT BEING SCHEDULED.

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