

# Specialty Service Referral

Sarah Bush Lincoln Health Center  
1000 Health Center Dr. • Mattoon, IL 61938



## REFERRING PROVIDER

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Reason for Referral \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Last 4# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_ County \_\_\_\_\_  
Insurance Carrier Primary \_\_\_\_\_ Secondary \_\_\_\_\_  
If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # \_\_\_\_\_  
Work Related  Yes  No If yes, Employer \_\_\_\_\_ Contact \_\_\_\_\_  
Work Comp Carrier \_\_\_\_\_ Contact \_\_\_\_\_

## INFORMATION NEEDED

Please include all the information below.

- Provider Notes
- Procedure Reports
- Appropriate Laboratory Reports
- Appropriate Imaging Reports
- Medication and Allergy Lists

Please indicate specialty needed for referral.

\_\_\_\_\_  
Preferred Provider

\_\_\_\_\_  
Appointment Urgency

- First available
- Urgent

## REFERRING RESPONSE

- Patient Scheduled

Provider \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Comment \_\_\_\_\_

- Patient NOT Scheduled

Additional Information Required \_\_\_\_\_  
Other Reason \_\_\_\_\_