1460 N 16TH AVE SUITE D YAKIMA, WA 98902
PHONE: (509) 574-3805
MEDICAL RECORDS FAX: (509) 225-2717

MEMORIAL Physicians PLLC

Referral Department
Phone: (509) 225-2002 FAX: (509) 249- 4450

❑ **Routine** ❑ **Urgent**

❑ **Emergent – *requires a Provider to Provider call to initiate, once faxed please call (509) 225-2002***

REQUEST FORM FOR CONSULTATIONS AND/OR PROCEDURES

PLEASE FILL OUT THIS FORM COMPLETELY TO IMPROVE HANDLING OF THE REQUEST

Patient Information

Last Name: _____ First Name: _____ Date of Birth: ___/___/___

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: ___-___-_____ Sex: ❑ M ❑ F Interpreter Needed: ❑ Yes ❑ No

Primary Insurance Plan: _____ Secondary Insurance Plan: _____

Identification#: _____ Identification#: _____

Group#: _____ Group#: _____

Policy Holder: _____ Policy Holder: _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Policy Holder Relationship: _____ Policy Holder Relationship: _____

Referral/Authorization#: _____ Referral/Authorization#: _____

Preferred Pharmacy: _____

Clinical Information

Referring Provider Name: _____ Referring Provider NPI: _____

Referring Provider Phone#: _____ Referring Provider Fax#: _____

PCP Name: _____

Diagnosis Description (s): _____

Diagnosis Code(s): _____

Requested Services

❑ Consult/Treat/Return when stable AND ❑ Include pain medication management***

****Please note that our providers may choose not to prescribe narcotics at the time of the initial pain medicine consult.*

❑ Consult/Make Recommendations Only ❑ Assume Full Pain Management

For those directing spine care

❑ New Patient Visit/Procedure Requested procedure _____

PLEASE PROVIDE COPIES OF PATIENT'S MEDICAL RECORDS TO ACCOMPANY THIS FORM

Date Sent: _____ Records Sent: ❑ Chart Notes ❑ Radiology Reports ❑ Lab Reports