



External

Referral Request

Thank you for choosing Marshfield Clinic Health System. **Please fax or email this form as well as any patient demographics, insurance information, applicable clinical notes, pertinent labs or imaging.**

Fax number: 715-858-9171 Email address: rf.westreferral@marshfieldclinic.org Questions – call: 1-877-857-3337

Date	Referring provider name		
Referring provider phone number		Fax number	
Practice name of referring provider			
Practice address of referring provider			
Patient name			Date of birth
Has patient received medical care under another name: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name _____			
Patient's contact number		Alternate	
Patient's home address			
Patient's primary care provider			
Referred to specialty		Location requested	
Specific provider (if desired)			

Urgency: Days Weeks Schedule permitting Elective

Emergent referrals require provider-to-provider contact with the on-call specialist. Call us at 715-858-9191 to assist with this.

Diagnosis/Complaint (clinical question to be answered) _____

If this referral is to the Pain Clinic, it is necessary to indicate if the patient is to be seen for:

Medication management Spine assessment Potential injection

If this referral is to Behavioral Health, it is necessary to indicate if the patient is to be seen for:

Medication management Counseling Neuropsychological testing The patient is a: Child Adult

Is this a work-related injury or illness: Yes No If yes, date of injury _____

Name of employer _____ Liability accident: Yes No

Other relevant labs/imaging (date, study, location) _____

Additional information (i.e. Does the patient have special needs, interpreter, hearing/visual impairment, etc.) _____

Thank you for putting your trust in Marshfield Clinic Health System.