Marshfield Clinic®

External

Referral Request

Thank you for choosing Marshfield Clinic. **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: ☐ Yes ☐ 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.

This Referral Request form is for internal processing only and is not part of the medical record.

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