UNM
Sandoval Regional
Medical Center, Inc.

Patient Name:
DOB:
MRN:

SRMC ENT/Audiology Clinic Phone: (505) 994-7397 Fax: (505) 994-7497

External Referral / Consult Request Form

Instruction: The following information will be required for review of your referral. Please submit complete packet to the fax number above and allow up to 8 days for review.

- ☐ **Patient Demographics & Insurance Information**
  - Please include patient name, address, best contact number, insurance name & policy number
  - Prior Authorization information for specialty clinic visit (obtain for minimum 3 visits)
- ☐ **Contact information for PCP and/or referring physician**
  - Please include address, phone and fax number
- ☐ **Consult Request / Referral**
  - What question do you need addressed by the specialist?
- ☐ **Recent Clinic/Progress Notes**
  - Last 3 visits (if applicable)
- ☐ **Recent Diagnostic Reports** (up to 3 months, pt to bring outside studies via disk)
  - Radiology: CT, MRI, X-Ray, etc.
  - Laboratory: CBC, UA, LFT, Pathology Report relating to diagnosis, Sensorineural Hearing Loss Profile
  - Other: EKG, ECHO, Hearing test
  - Vestibular: VNG, OVEMP, CVEMP, VHIT, EcochG, ABR
  - Implant evaluation (if any)
- ☐ **Current Medication List**

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Patient Appointment Status – For UNM Hospitals Use Only

☐ Appointment has been made with Dr. __________________on ___________ at _____am/pm

☐ Not able to schedule appointment due to:

__ Incomplete information for referral review

Comments:

__ Patient declined appointment

__ Recommend appointment with the following specialty ___________________.

We have forwarded your referral to the above at: ________________________

☐ Consultation via phone. Please call (888) UNM –PALS to discuss this referral.

Clinical Reviewer Signature: ______________________ Date: __________ Doc in EHR: Y / N