Premier Health

Premier Physican Network
Referral for Specialty Services

(937) 341-8991 Fax **PremierPhysicianNet.com**

Refer to Practice:

_____

❑ First Available

Refer to Provider:

_____

❑ First Available

_____

❑ **CARDIOLOGY**
❑ General Cardiology
❑ Electrophysiology
❑ Heart Failure
❑ Interventional Cardiology
❑ Structural Heart

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❑ **CARDIOTHORACIC SURGERY**
❑ Cardiac
❑ Esophageal
❑ Thoracic

_____

❑ **ENDOCRINOLOGY**
❑ Diabetes Management
❑ Other

_____

❑ **ENT**
❑ General ENT
❑ Head and Neck Surgery/ Reconstruction

_____

❑ **FAMILY PRACTICE**

_____

❑ **GASTROENTEROLOGY**
❑ Antibiotic Therapy
❑ Hepatitis
❑ HIV
❑ Infectious Disease

_____

❑ **INTERNAL MEDICINE**

_____

❑ **MEDICAL ONCOLOGY/ HEMATOLOGY**

_____

❑ **NEUROLOGY**
❑ General Neurology
❑ Brain Mapping
❑ Epilepsy
❑ Headache
❑ Memory
❑ Movement Disorders
❑ Multiple Sclerosis
❑ Neuromuscular
❑ Neuro Interventional Radiology
❑ Traumatic Brain Injury (ages 18-40)

_____

❑ **NEUROSURGERY**
❑ Functional
❑ Spine
❑ Tumor
❑ Other

_____

❑ **OBGYN**
❑ Gynecology
❑ High Risk Pregnancy
❑ IOTA Scan
❑ Obstetrics
❑ Other

_____

❑ **ORTHOPEDICS**
❑ Hand/Wrist & Reconstruction
❑ Hip
❑ Knee
❑ Shoulder
❑ Spine
❑ Sports Medicine
❑ Trauma
❑ Other

_____

❑ **PEDIATRICS**

_____

❑ **PHYSICAL MEDICINE**
❑ EMG
❑ Non Surgical Pain Relief
❑ Rehabilitation
❑ Other

_____

❑ **PULMONARY & CRITICAL CARE**
❑ Pulmonology
❑ Other

_____

❑ **PSYCHIATRY**
❑ Adult
❑ Pediatrics/Adolescent

_____

❑ **RHEUMATOLOGY**

_____

❑ **SURGERY**
❑ General
❑ Breast
❑ Colorectal
❑ Gynecologic Oncology
❑ Plastics
❑ Surgical Oncology
❑ Vascular
❑ Weight Loss

_____

❑ **UROLOGY**

_____

❑ **WOUND**
❑ Burn
❑ Wound

Date _____

Patient Name _____

Date of Birth _____

Address _____

Phone _____

Insurance _____

BWC (please list claim #) _____

Are interpreter services required ❑ Yes ❑ No

Language _____

Referring Physician _____

Physician Phone _____

Pre-Authorization Number _____

Reason for Referral/Consultation _____

_____

_____

_____

Medications _____

_____

Instructions _____

_____

If Patient Needs Surgery, is Patient Medically Cleared ❑ Yes ❑ No

Allergies _____

Evaluate, Treat and Send Back with Treatment Plan ❑ Yes ❑ No

Accompanying Documents ❑ Labs ❑ X-ray ❑ CT ❑ MRI ❑ EMG ❑ EKG ❑ Patient Demographics ❑ Patient Insurance Card

If not in Epic: Please fax demographic sheet, insurance card(s) front and back, office notes, and relavant testing to our office.