Western University Patient Care Center

795 E. Second Street
Pomona, CA 91766-2007
Main: 909-706-3900

Interdepartmental Referral Form

Today's Date: _____

Patient being referred to: (check one)

	Dental (x 3910)		Pediatrics (x 2565)
	Eye Care (x 3899)		Pharmacy/Anticoagulation (x 3730)
	Family Medicine (x 2565)		Physical Medicine & Rehabilitation (x 2565)
	Foot and Ankle (x 3877)		Western Diabetes Institute (x 3779)
	Osteopathic Manipulative Medicine (x 2565)		

Date of exam: _____

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **Self-Pay or Insurance: (Policy#)** _____

Diagnosis: _____

Reason for referral:

_____ Evaluation and management
_____ Co-management
_____ Second opinion
_____ Other

_____
_____
_____

Priority:

- Stat (1-7 days)
- Urgent (8-14 days)
- Routine (15-30 days)

Referred by:

_____

Report requested: No / Yes (send to) _____

Insurance Authorization # _____ Referral valid for _____ visits or _____ months

(Note: Dental services do not require insurance authorization for referral services)