Project Access San Diego

Referral Form Requirements:

- Please make sure patient information is filled out completely and is legible.
- Make sure to fill out "Referral Request" and "PCP Information" sections even if you are faxing your own clinic referral page.
- Under "Clinic Information" include the appropriate referral coordinator information. This is the person we will contact to notify status of application and to coordinate care with specialist.
- Referral form must be signed and dated.

*IF REFERRAL FORM IS NOT COMPLETE AND SIGNED, THEN WE WILL SEND IT BACK. THIS FORM MUST BE COMPLETED IN ORDER FOR US TO SEND OUT THE REFERRAL. *

Please include the following with referral form:

- **Last three visit notes related to the referral**
- **Relevant emergency room, hospital and consultant reports**
- **Related labs or imaging/diagnostic reports (if applicable)**
  - *GYN:* Include most recent PAP smear and endometrial biopsy.
  - *Cardio:* Include ECG/EKG or other tests that they may have done.
  - *Endocrinology:* thyroid labs

How to fax referrals:

- Fax completed materials to (858)560-0179 in the following order:
  - Project Access Referral Form
  - Relevant medical notes, labs, and/or imaging
  - PASD Application (6 pages)
  - Supporting documents (proof of income, copy of valid ID, etc.)

CHAMPIONS *for* HEALTH
PHYSICIANS IMPROVING HEALTH CHANGING LIVES

Project Access San Diego Patient Referral Form

Fax completed form, relevant medical records, and PASD application to (858) 560-0179

Patient Information			
Name:		DOB:	
Gender:		Preferred Language:	
Home Phone:		Cell Phone:	
Mailing Address			
City, State, Zip			

Referral Request

Imaging Referral		Specialty Care Referral	
Diagnosis Description:	ICD-10	Diagnosis Description:	ICD-10
Imaging Requested:	CPT	Specialty Requested:	CPT

Please check all that apply:

- ☐ Brain aneurysm clip
- ☐ Implanted electrical devices
- ☐ CKD
- ☐ Iodine allergy
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Dialysis
- ☐ Renal disease
- ☐ Metal foreign body in eye

☐ With Contrast ☐ Oral ☐ IV

***Must include** BUN_____ Creatine _____
(levels within the last 90 day period)

☐ Without Contrast

Reason for Consultation:

☐ Diagnosis Only

☐ Diagnosis & Treatment Plan Only

☐ Diagnosis and treatment then further care with primary care provider

Clinic Information	
Community Clinic Name:	
Address:	
City, State, Zip Code:	

Referral Coordinator Name:	Referral Coordinator Direct Number:
Referral Coordinator E-mail:	Office Fax:

Primary Care Physician Information	
Provider Name:	Physician/Nurse Direct Line:
Provider E-mail:	Office Fax:

Provider Signature: _____ **Date:** _____