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

Diagnosis Description:	ICD-10
Imaging 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

Specialty Care Referral

Diagnosis Description:	ICD-10
Specialty Requested:	CPT

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:** _____