Patient Name:

DOB:

MR #:

Index to Consult/Referral/Transfer

Date: _____

EPIC/UWHC#: _____

UW Health
(SwedishAmerican Hospital)

REQUEST FOR CLINIC APPOINTMENT – ROCKFORD REFERRALS

For urgent referrals, call to speak with a physician at 779-696-2050.

This form may be used to request an appointment in any UW Health – Rockford location.

Please provide all required (*) information. Missing information may result in delayed processing of this request.
We may contact the patient directly for additional information, please notify the patient of this appointment request.

Patient Information

Patient Name*: _____

Patient Address*: _____

Preferred Contact: ☐ Patient ☐ Parent/Guardian ☐ POA

☐ Other _____

Preferred Contact Name: _____

Primary Phone number*: _____

Date of birth*: _____/_____/_____

Sex*: ☐ Male ☐ Female ☐ X ☐ Nonbinary

City*: _____ State*: _____ Zip*: _____

Interpreter needed? ☐ No ☐ Yes Language: _____

Insurance Information

Name of insurance*: _____

Subscriber/Member/Employee ID #*: _____

Authorization Approval Number: _____

Subscriber name*: _____

Group number: _____

***Please fax a copy of the insurance card with the request form if possible.**

Provider Information

Referring Provider Name*: _____

Clinic Name*: _____

City: _____

Contact Person Within Your Clinic

Name*: _____

Phone #*: _____

Primary Care Provider and Clinic: _____

Specialty Requested

Specialty Clinic(s) requested: _____

Physician/NP/PA requested: _____

Has the patient previously been seen by a specialist for this problem? ☐ Yes ☐ No

If yes, who did they see and date of last visit? _____

Related testing that has been done regarding the above diagnosis: _____

_____

Please include any medical records, reports, or test results which are pertinent to this referral

PLEASE FAX INFORMATION TO: (608) 267-8148

Referring Provider Signature: _____ Date: _____/_____/_____ Time: _____ Pager#: _____

This form is for use by non-UW Health providers