REFERRAL FORM

PAAS PRIMARY CARE PROVIDER (PCP)		
Printed Name of PAAS PCP	Office Telephone Number	Fax Number

PATIENT INFORMATION			
Name of Patient Being Referred	Birthdate	Name of Parent or Guardian ☐ Not Applicable	
Patient's Medicaid Number:			
Street Address of Patient	City	State	Zip Code
Patient's Diagnosis		Telephone Number of Patient	

REFERRAL INFORMATION

Note: Pertinent portions of the patient's medical record (including a complete history, a statement of the current problem(s) and a current medication list) are to be forwarded prior to the first visit with the specialty provider.

Reason for Referral

Type of Service Requested:

☐ Consultation Only ☐ Evaluation & Treatment

☐ Office Visits _____(Maximum number)

☐ Treatment limited to: _____
(Note: New Authorization required every 180 days)

Diagnostic Studies and Durable Medical Equipment:
☐ can be ordered ☐ cannot be ordered without consultation with PCP listed on the first line of this form

Date and Time of Appointment	Start Date of Referral _____
_____ ☐ Appointment not made. Patient is to call for an appointment.	End Date of Referral _____

SPECIALTY PROVIDER INFORMATION

Note: A Consultation, Evaluation, and/or Treatment Report must be completed and returned to the PAAS Primary Care Provider. If a referral to another specialist is required, the PAAS Primary Care Provider listed above must approve that referral and complete a new referral form.

Specialty Provider's Name	Specialty Provider's Telephone Number	Fax Number	
Street Address of Specialty Provider	City	State	Zip Code

PAAS PRIMARY CARE PROVIDER'S SIGNATURE		
Signature of Patient's PAAS PCP	PAAS Provider Number	Date

A COPY OF THIS REFERRAL FORM IS TO BE FILED IN THE PATIENT'S MEDICAL RECORD

Revised 7/20/00