SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM
751 S. BASCOM AVE.
SAN JOSE, CA 95128
(800) 814 - 4351

SANTA CLARA VALLEY MEDICAL CENTER

MR#

VE#

CONSULTATION / REFERRAL FORM

PATIENT

Patient's Name (Print) Last First Middle If minor, Guarantor Name

Date of Birth Patient Phone Sex: M or F Translator Needs: Yes [ ] No [ ] If Yes, Language:

Address City State Zip

REQUESTOR

Referring Physician & Clinic Name Today's Date

Requestor Address City State Zip

Phone Ext# Fax Physician Email Address

REQUEST

SPECIFIC SERVICE REQUESTED:

Specialty BURN CLINIC

TYPE: [ ] CONSULTATION (N) REFERRAL

Request for Opinion or Advice in Diagnosis and/or Treatment

Request for Care of Specific Problem or for Transfer of Care

WHEN: (N) URGENT [ ] ROUTINE

Urgent referral require prior conversation between MD to MD. Provide name of MD contacted. Please call (408) 885-5000 & ask the operator to page the On-Call specialty MD.

Name MD contacted Appt Date / Time (If given)

LEGIBLE DESCRIPTION OF THE REASON FOR REFERRAL, DIAGNOSIS, AND RELEVANT CLINICAL INFORMATION (attach any necessary reports, tests, etc.)

ICD10 CODE: 1/ 2/ 3/ 4/

PROGRESS NOTES AND LAB/X-RAY REPORTS MUST BE SENT WITH REFERRAL

Requested by Must Print Requesting Physician Name, LIC# & NPI# Requesting Physician Signature

Form Completed By: Print Name Phone#

OUTPATIENT CONSULTATION

REFERRAL GUIDELINES

Please fax referral with all the listed information below to (408) 793-1892 or (408) 885-3535

- [ ] **CURRENT DEMOGRAPHIC INFORMATION (Face Sheet)**
- [ ] **PROGRESS NOTES**
- [ ] **REPORTS**
- [ ] **AUTHORIZATION**
- [ ] **COPY INSURANCE CARD**

Please note the **REFERRAL WILL NOT BE PROCESSED** until information is received. Paper referrals **WILL NOT BE ACCEPTED** for providers with access to **VALLEY EXPRESS. Referrals received incomplete or illegible will be returned.**

SANTA CLARA VALLEY MEDICAL CENTER
REFERRAL REGISTRATION FORM

VHP / AUTHORIZATION CENTER
2480 N. 1ST STREET #200
SAN JOSE, CA 95131
(408) 885-3820

PATIENT'S DEMOGRAPHIC INFORMATION:

LAST NAME:_____ FIRST:_____ MIDDLE:_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ SEX: M OR F

HOME ADDRESS: _____ CITY_____ STATE_____ ZIP CODE_____

HOME PHONE / CELL #: (_____)_____ BIRTH PLACE:_____

U.S. CITIZEN: YES / NO MARITAL STATUS:_____ ETHNICITY:_____ COUNTY:_____

RELIGION:_____ LANGUAGE:_____ MOTHER'S MAIDEN NAME (LAST) :_____

ARE YOU EMPLOYED: YES / NO EMPLOYER NAME:_____ OCCUPATION:_____

INSURANCE INFORMATION: (PPO, HMO, MECI-CAL, & HEALTHY FAMILY OR KIDS)

INSURANCE TYPE:_____ GROUP # _____ PHONE _(____)_____

I.D. #: _____ SUBSCRIBER'S NAME:_____ DATE OF BIRTH:_____

EMPLOYER NAME:_____ OCCUPATION:_____

INSURANCE BILLING ADDRESS:_____

GUARANTOR'S INFORMATION:

PARENT'S NAME: _____ RELATIONSHIP: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

EMERGENCY CONTACT PERSON: (DIFFERENT TELEPHONE # FROM PT)

NAME: _____ RELATIONSHIP: _____

PHONE / CELL #: _(_____)_____

PLEASE FILL OUT THE INFORMATION ABOVE AND FAX IT BACK TO VMC AUTH DEPT. AS SOON AS POSSIBLE.
REGISTRATION FORM MUST BE COMPLETED & RETURN TO VMC AUTHORIZATION DEPARTMENT BEFORE YOUR APPOINTMENT. PLEASE FAX IT TO **(408) 793-1892**. THANK YOU!