Virginia Mason Memorial

Phone: 509 / 225-2002
Fax: 509 / 249-4450

Memorial Physicians / Referrals

Priority: ❑ Routine ❑ Urgent ❑ STAT

Please provide the following information and fax to 509 / 249-4450.
Call 509 / 225-2002 after faxing an emergent referral, this will allow better assistance for timely care.

PATIENT INFORMATION

Last Name: ______________________ First: ______________________ Date of Birth: ____/____/____

Address: ______________________ City: ______________________ State: ________ Zip: ____________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

SSN: ______ - ______ - ______ Gender: ❑ M ❑ F ❑ T Interpreter Needed: ❑ Y ❑ N ______ Preferred Language

Name of Employer: ______________________ City: ______________________

Guarantor Name: ______________________ Guarantor Date of Birth: ____/____/____ Gender: ❑ M ❑ F ❑ T
(If patient is under 18)

Primary Insurance Plan: ______________________ Secondary Insurance Plan: ______________________

Identification#: ______________________ Identification#: ______________________

Group#: ______________________ Group#: ______________________

Authorization#: ______________________ Authorization#: ______________________

Policy Holder Name: ______________________ Policy Holder Name: ______________________

Policy Holder Date of Birth: ____/____/____ Relationship: ❑ Spouse ❑ Parent ❑ Other Policy Holder Date of Birth: ____/____/____ Relationship: ❑ Spouse ❑ Parent ❑ Other

Worker's Compensation or MVA Insurer Name: ______________________

Claim#: ______________________ Date of Injury: ____/____/____ State: ____________

Claims Manager Name: ______________________ Phone#: ______________________ Fax#: ______________________

Preferred Pharmacy: ______________________

CLINICAL INFORMATION

Referring Provider Name: ______________________ PCP Name: *(If different from Referring Provider)* ______________________

Referring Provider NPI: ______________________ Phone#: ______________________ Fax#: ______________________

Reason for referral:
(For Water's Edge only)

❑ Consult/Make recommendations only
❑ Include pain medication management
❑ Consult/Treat/Return when stable
❑ Assume full pain management

Reason for Referral: ______________________ **Diagnosis Code(ICD-10):** ______________________

REQUESTED TREATING SPECIALTY CLINIC

❑ Memorial Sleep Specialists
❑ Yakima Ear, Nose and Throat
❑ Lakeview (PT excluded)
❑ Water's Edge 509 / 574-3805
❑ Yakima Gastroenterology
❑ Yakima Vascular Associates
❑ Yakima Endocrinology Associates 509 / 574-3805
❑ Wound Care and Hyperbaric Services

******Yakima Endocrinology and Water's Edge require a peer to peer for all emergent patient care, call the number listed next to the clinic name prior*******

Peer to Peer Provider Name: ______________________ **Preferred Treating Provider:** ______________________

*****THESE PATIENT MEDICAL RECORDS PERTAINING TO THE DIAGNOSIS NEED TO ACCOMPANY THIS REFERRAL*****

❑ Chart Notes ❑ Vascular Studies ❑ Radiology Reports ❑ Lab Reports *(to be included with all blood related diagnosis)*