

Adventist Health Referral Request

We appreciate the opportunity to care for your patient.



Fax: 800-305-0456 | Phone: 877-906-3388 | Email: Referrals@ah.org (Please do not send PHI via e-mail).

PowerChart Users: AH Referral Admin. Subject line should read "Physician Referral."

Direct Messaging: ReferToAH@direct.ah.org

Routine Date: _____

Urgent No. of Pages: _____

Referring provider information:

Referred by (MD): _____ Medical Group: _____

Phone: _____ Fax: _____ PCP _____

Address: _____ City: _____ Zip: _____

This form completed by: _____ Phone: _____

Patient information: (Please provide copy of patient demographics/face sheet)

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Phone: _____ Gender: Male Female

Patient Address: _____

City/State/Zip: _____

Reason for referral:

Service/Specialty Requested: _____ Diagnosis/ICD: _____

Physician Requested (if applicable): _____

Service Requested: Consultation Tele-Health 2nd opinion Follow up Surgery

Other (please specify): _____

Reason for Referral: _____

Documentation required: (Please provide the following with this form)

✓ Relevant clinical notes and test results, i.e., history & physical, MRI/CT/X-ray

✓ Insurance Information

✓ Authorization information (if required)

Interpreter needed? Yes No Language: _____