

**Denver Health  
Specialty Clinic Referral Form**



Fax completed forms to **720-956-2320**; please allow 2 business days for processing.

***Urgent requests, please call the appointment center at 303-628-1550 after faxing the completed form.***

***\*\*This form is not to be used for Radiology/Imaging\*\****

**Patient Information**

Name (First, Middle, Last)

If child, name of parent/guardian/caregiver:

Date of birth

Sex

Male

Female

Phone Number(s):

Address:

Interpreter Needed?

Yes

No

Preferred Language

**Insurance Information**

Insurance Carrier:

Member ID:

Subscriber Name:

**Referral Information**

Priority

Routine

Urgent (call after submitting)

Elective

Diagnosis and/or ICD-10:

Clinic / Specialty Requested:

Clinical Question (if referral marked urgent, please include the reason for urgency):

ACP Definitions of Care (choose one)

Consultation

Co-management with Principle Care

Co-Management with Shared Care

Complete Transfer

**Referring Provider Information**

Referring Provider Name:

Practice Name and Address:

Phone and Fax:

Email:

PCP Name + Phone (if different from above)

**Additional Information**

*Included Relevant Clinic Notes (History + Physical, Imaging, Lab Results, etc.)*