Denver Health
Specialty Clinic Referral Form

Fax completed forms to **303-602-0838;** please allow 2 business days for processing.
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.)*