



Denver Health Referral Form

Fax completed referral form to: 720-956-2320

Please allow 2 business days for processing. **For urgent requests, please call the appointment center at 303-628-1550 after submitting the completed form.**

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

Patient Information		Referral Information	
Name (First, Middle, Last) Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Priority: Routine <input type="checkbox"/> Urgent <input type="checkbox"/> (call after submitting) Elective <input type="checkbox"/>	
If child, name of parent:		If Urgent, please describe:	
Date of Birth:		Diagnosis and/or ICD 10:	
Phone #	Secondary Contact #	Clinic / Specialty Requested:	
Address		Clinical Question:	
City	Zip Code	State	
Interpreter Needed? Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/> Consultation <input type="checkbox"/> Co-Management Shared Care <input type="checkbox"/> Co-Management Principle Care <input type="checkbox"/> Complete Transfer <input type="checkbox"/> Procedure	
Preferred Language:			
Insurance Information:			
Insurance Carrier:		Member ID:	
		Subscriber Name:	
Referring Provider Information			
Referring Provider Name		Phone	
Practice Name		Fax	
Practice Address		Email	
Practice City/State/Zip Code		NPI #	
PCP Name		PCP Phone	

Additional Documentation Included

Relevant Clinical Notes (History & Physical, Imaging and Lab results)

EpicCare Link

Send and manage
referrals online 

<https://epiccarelink.denverhealth.org>