Dartmouth-Hitchcock

Outpatient Appointment Referral Form

Lebanon
Toll free: 1-866-DHMC DOC (346-2362)
Locally, dial (603) 653-1999
Fax: (603) 676-4080

Concord/Keene/Manchester/Nashua:
Toll free: 1-866-833-4685
Phone: (603) 440-7680
Fax: (603-727-7776)

Thank you for this referral. Please complete the information below, so we may process your request in a timely manner. We will contact your patient prior to scheduling and your office will be notified when an appointment has been secured.

Referring provider: _____ Office #: _____

Practice name: _____ Fax #: _____

Contact person:_____ Phone #: _____

Staff physician: *(if different than above):* _____

Patient name: _____ **DOB:** _____

Former name(s):_____ If patient under 18, Parent/Guardian Name: _____

Mailing address: _____

Home: _____ Work: _____ Cell: _____

Is a D-H Interpreter needed for this appointment? YES NO

PCP: *(if different than above):* _____ Office #: _____

**Insurance – (Required Field): _____ Policy #: _____

**Group #: _____ Subscriber Name:_____ Subscriber DOB:_____

**Please include copy of the card with records

Clinic Requested

Section/Clinic: _____

Consultation Provider Request (if available)_____

Presenting Symptoms/Diagnosis

_____

_____

- ❑ Management of Care
- ❑ Evaluate and treat
- ❑ Second Opinion
- ❑ Assume a subset of care

Urgency

EMERGENT MEDICAL ISSUE – Please call the section to arrange the appointment (24 – 72 hours)

- ❑ Medically Urgent (72 hours-2 Weeks)
  May require a provider-to-provider phone call
- ❑ Routine/Non-Urgent
  D-H will work with patient to schedule

Notes associated with this request:

- ❑ Other instructions:_____

_____

- ❑ Notes are available in eD-H EMR
- ❑ Pertinent office notes with medication/dosage listing are attached
- ❑ Pertinent lab and radiology reports are attach