DARTMOUTH-HITCHCOCK • MANCHESTER

100 Hitchcock Way
Manchester, NH 03104
Phone: 603-695-2840 Fax: 603-695-2985

Surgery Referral

Date: _____

Patient Name: _____ DOB: _____

Referring Provider: _____ PCP:_____

Preferred Provider: _____

How soon:
☐ Non-Urgent
☐ Soon (Within 3-4 weeks)
☐ Urgent (In addition to completing this form, please call the specialty department for as provider to provider discussion)

Reason/Diagnosis:

Specific Question to be answered:

Please indicate your intention of this referral by placing an "X" in all boxes that apply:

	Consult only		**Second Opinion**
	Consult and Diagnostic testing		**Other: (Please explain)**
	Consult and Treatment		

Data previously obtained to evaluate symptoms: (please indicate dates that address this issue)

Labs:

Notes:

Radiology:

Other:

IN ORDER FOR APPOINTMENT TO BE SCHEDULED, ALL PERTINENT OFFICE NOTES, MEDICATION LIST, LABS AND RADIOLOGY REPORTS NEED TO BE MAILED OR FAXED to (603) 695-2985.