ALBANY MED Health System

ALBANY MEDICAL CENTER

Please fax this form and pertinent records

Referral Request Form

Date: _____

Patient Demographics

Patient first name:	**Home/ work phone:**	**Patient DOB:**
Patient last name:	**Cell phone:**	☐ **M** ☐ **F**
Other names known by:	**Street address:**	
Patient email:	**City, State, ZIP:**	

Referral Information

Diagnosis/ reason for referral:

Referring to: (Provider or Dept.) **NPI** (required)

Please fax all pertinent records for review PRIOR to patient's appointment. ☐ Complete and current problem list ☐ Lab results
☐ Imaging results ☐ Insurance prior auth/reference number _____ ☐ History and Physical ☐ Medication History
☐ Allergy History ☐ Growth charts (pediatric) ☐ Recent clinical notes specific to referral ☐ Other:

Requested time frame for visit: ☐ Urgent/0-5 days ☐ ASAP/6-10 days ☐ Standard new visit (within 14 days) ☐ Other:

Referring provider:	**Phone:**	**FAX:**
Office contact to send appointment to:	**Phone:**	**FAX:**
Notes:	**NPI** (required)	

Primary Insurance Information

Insurance company name:	**ID/Policy #:**	**Group #:**
Subscriber:	**Relationship to subscriber:**	**Subscriber DOB:**

Secondary Insurance Information (if applicable)

Insurance Company Name:	**ID/Policy #:**	**Group #:**
Subscriber:	**Relationship to subscriber:**	**Subscriber DOB:**

Guarantor

Guarantor name (if patient is under 18)**:**

Address:	**Relationship to patient:**	
City, State, ZIP:	**Phone:**	**Guarantor DOB:**

Continue ONLY for OBGYN and GI Referrals

Family Planning

Services Requested (check all that apply)

- ☐ Termination of Pregnancy
- ☐ Management of abnormal pregnancy/miscarriage
- ☐ Complex Contraceptive Consult
- ☐ Other:

Additional Clinical Details:

Dating Ultrasound

_____ **w** _____ **d on** _____

LMP: _____

- ☐ Sure
- ☐ Uncertain
- ☐ Unknown
- ☐ N/A (patient not pregnant)

Maternal Fetal Medicine

Services Requested (check all that apply):

- ☐ Amniocentesis
- ☐ Consideration for Transfer of Care
- ☐ Genetic Counseling
- ☐ Non Stress Test (NST)
- ☐ Biophysical Profile (BPP)
- ☐ Doppler
- ☐ Genetic Screening (1st trimester, sequential, or integrated)
- ☐ Chorionic Villus Sampling (CVS)
- ☐ Fetal Echocardio gram
- ☐ MFM Consultation
- ☐ Ultrasound, Consult, if needed
- ☐ Other:

Dating Ultrasound

_____ **w** _____ **d on** _____

LMP: _____

- ☐ Sure
- ☐ Uncertain
- ☐ Unknown
- ☐ N/A (patient not pregnant)

Best ECD: _____

Based on:

- ☐ LMP
- ☐ Ultrasound
- ☐ Other: _____

Gastroenterology

Does patient require isolation: ☐ Yes ☐ NO

PROCEDURE REQUESTED

- ☐ Anal Manometry – Albany Only
- ☐ Band adjustment – Albany Only
- ☐ Barrx – Albany Only
- ☐ BRAVO
- ☐ Bronchoscopy
- ☐ Pleural manomtery – Albany Only
- ☐ **Colonoscopy**
- ☐ Endoscopy (EGD)
- ☐ ERCP- Albany Only
- ☐ Endoscopic Ultrasound – Albany Only
- ☐ EBUS with Fluro – Albany Only
- ☐ 24-hour Esophageal pH with 2% lidocaine
- ☐ Esophageal Manometry
- ☐ Impedance pH 24-hour with 2% lidocaine

☐ Other:

INDICATIONS

- ☐ Abnormal x-ray study
- ☐ Anemia
- ☐ Barretts
- ☐ Colon cancer screening
- ☐ Diarrhea
- ☐ Dysphagia
- ☐ Colon cancer/colon polyps

FAMILY HISTORY

- ☐ GERD
- ☐ Heme + Stool
- ☐ Iron deficiency / Anemia
- ☐ Lung CA
- ☐ Morbid obesity
- ☐ Colon cancer/colon polyps

PERSONAL HISTORY

- ☐ Rectal bleeding
- ☐ Weight loss
- ☐ Other: