PATIENT FAX REFERRAL FORM

Today's Date ______________________________

Referring Provider Name ______________________________

City ______________________________

State ______________________________

Phone ______________________________

<u>PATIENT INFORMATION</u>

First Name ______________________________

Middle Initial ______________________________

Last Name ______________________________

City ______________________________

State ______________________________

Birth Date ______________________________

Phone ______________________________

Alternate Number ______________________________

Parent's Name ______________________________
(If Patient is a Minor)

Does the Patient need an Interpreter? ______________________________

Patient's Insurance Carrier ______________________________

Reason for Referral ______________________________

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(Please be specific – what is the clinical question to be addressed?)

Physician Communication Line: 406-HELPNOW (406-435-7669)

Visit **www.billingsclinic.com/referringproviders** for a list of specialty-service fax numbers.