Referral Form

For routine referrals, fax completed form to 575-728-8572.
For urgent referrals (appointment within two weeks),
provider should call our office directly at 877-760-0370

Choose the Type of Referral *
- ❒ Diagnose and Treat (Co-Manage)
- ❒ Consultation
- ❒ Transfer of Care
- ❒ Trauma Assessment (Private Pay)

Please consult with me, the primary care provider, before making secondary referrals.
- ❒ Yes
- ❒ No

Provider Information

UPIN Number / NPI *

Referring Provider Name *

Referring Provider Email Address

Primary Care Provider (❒ Same as Referring Provider)

Clinic Information

Clinic Name

Street Address

Address Line 2

City

State / Province / Region **Postal / Zip Code**

Country

Clinic Phone Number

Clinic Fax Number

Additional Contact Name

Additional Contact Phone Number

Patient Information

Is family/patient aware of the referral? Yes ❒ No ❒
If No, please make them aware as soon as possible.

Patient Name *

Date of Birth *

Gender*
- ❒ Male
- ❒ Female

Patient Address

Street Address

Address Line 2

City

State / Province / Region **Postal / Zip Code**

Country

Primary Contact

Relationship to Patient

Primary Phone Number

Alternative Phone Number

Preferred Language

Preferred Gillette Clinic Location (if known)

Specialty Area to be Referred

Or, let the Clinician determine the appropriate specialty.
- ❒ Yes

Specific Name of the Provider I Would Like to Refer to

Continued on back.

*This information is required to complete a referral.

Patient Information (continued)

Reason for Referral:*

Diagnosis/Symptoms:*

Additional Medical History Information:

Additional Documents:

Our Clinican have requested documentation to assist us in the care of your patient. Please fax the following documents to medical records at 575-728-8572

- Patient face sheet.*
- Clinic notes, including diagnoses or problem lists.
- Relevant family history.
- Relevant test (lab or imaging) results.
- Current medication list and allergies.
- Current care management plans or recent referrals for therapies, medical equipment, etc.
- Diagnosis of mental health condition, substance abuse or behaviors affecting health.

*This information is required to complete a referral.