Health Connections

Appointment Request / Referral Form

Requesting Provider Information: PLEASE PRINT CLEARLY

Date of Request	
Provider Name	**FIRST NAME:** **LAST NAME:** **NPI#:**
Phone Number	( ) -
Fax Number	( ) -
Name of Person Completing Form	

Client Information: PLEASE PRINT CLEARLY

Client Name	**FIRST NAME:** **M.I.:** **LAST NAME:** **PREFERRED NAME:**	
Date of Birth		**Gender:** __M __F __ M to F __F to M __ Other
Phone Number	( ) -	Alt. Number ( ) -
Street Address		
City, State, Zip		
Insurance		
Reason for Referral	__ Primary Care __ PrEP __PEP __HIV __Hep C __Trans Health __COVID-19 __Women's Health __Other (please specify)_____ _____	

Check type of appointment needed below. Please include chart notes and insurance card if available.

☐ **Emergent**
See today

☐ **Urgent**
See tomorrow Or next Business day

☐ **Routine**
See within 7 business days

☐ **Verbal Consult**
Patient is in the referring office at time of scheduling. GMC completes form over the phone. Person calling: _____

☐ **Referral Only**
Patient is being referred without being seen (referral necessary for Insurance)

Please fax this form to our office at **(414) 269-8280**.

If the patient is in your office and you need immediate service please call us at **(414) 269-8282.**

For additional forms or to complete this form **online** go to **healthconnectmke.org/provider-referrals**