Complete and print.

Reset Form

MAYO CLINIC

TO BE SCANNED

# *Referral to Mayo Clinic Health System*

Form content retained in medical record.
**Route to HIMS Scanning.**

*(complete fields or place patient label here)*

| Patient Name *(First, Middle, Last)* | |
|---|---|
| Birth Date *(mm-dd-yyyy)* | Room Number (if applicable) |
| Mayo Clinic Number | |

**Select Location:** ☐ Eau Claire ☐ La Crosse ☐ Mankato

**Instructions:** Print and fax completed document with any pertinent medical records, including radiology imaging and insurance card (back and front), to 855-392-9335 or 608-392-9814. To submit via phone, call 855-392-8400 or 608-392-9816.

## Patient Information (Print; do not use label.)

| Sex: ☐ Male ☐ Female | |
|---|---|
| Address *(Street, City, State, ZIP Code)* | |
| Home Phone | Other Phone |

## Insurance Information

| Subscriber Name *(First, Middle, Last)* | Subscriber Insurance Number |
|---|---|
| Insurance Plan Name | |
| Guarantor Name *(First, Middle, Last)* | Date *(mm-dd-yyyy)* |
| Guarantor Address *(Street, City, State, ZIP Code)* | |

## Appointment Request Information

| Location Requested | Department Requested | Specialty Requested | Provider Requested |
|---|---|---|---|
| Appointment Timeline: ☐ Urgent (less than 3 days) ☐ 4–14 days ☐ Routine ☐ Other _____ | | | |
| Chief Complaint (Diagnosis and ICD-10) | | | |
| Specific Tests Ordered (eg, Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US) | | | |

## Referring Provider Information

| Referring Facility Name | | |
|---|---|---|
| Referring Provider Name *(First, Middle, Last)* | Person Completing Name *(First, Middle, Last)* | |
| Email | Phone for Questions | Fax |

## Signature

| Ordering Provider Signature ▶ Signature Required | Date *(mm-dd-yyyy)* | Time *(hh:mm 24-hour clock)* |
|---|---|---|
| Ordering Provider Printed Name *(First, Middle, Last)* | | |

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Print