BASTYR CENTER
FOR NATURAL HEALTH
the teaching clinic of Bastyr University

Bastyr Referral Request

Patient name (last, first, middle initial): _____Date _____ / _____ / _____

Date of birth: _____ / _____ / _____ Home phone : (_____) _____ Gender ☐ Male ☐ Female

Patient preferred language for health care communication: _____

Patient address: _____

Patient insurance company and policy number: _____

_____

Referral From

Referring provider's name (last, first): _____ NPI: _____

Contact number (_____) _____ Provider's fax (_____) _____

Provider's address: _____

Primary care provider's name: _____

Referral To

Provider's name or department: _____

Mark appropriate need: ☐ Routine ☐ Urgent ☐ Emergent (referring doctor must call and speak to on-call provider)

Reason for Referral (include diagnosis)

Mark appropriate need: ☐ E/M ☐ Consult ☐ Treatment

Mark appropriate need: ☐ Coordination of Care ☐ Transfer of Care

Additional comments/details: _____

_____

_____

_____

_____

Please fax referral, chart notes, current lab work and radiology reports to:

206.834.4131 Attn: Referral Coordinator/Provider's name