El Camino Women's Medical Group

Obstetrics & Gynecology

❑Routine
❑Urgent

Minimally Invasive Surgery Clinic
Referral Request Form

Thank you for choosing El Camino Women's Medical Group.
We look forward to collaborating with you in your patient's care.

Date_____

FAX: 650-336-7359
EMAIL: info@elcaminowomen.com

Referring Information:

Referred by (Physician):

_____

Address: _____ Phone: _____-_____-_____

_____ Fax: _____-_____-_____

_____

Patient Information (Please provide copy of patient insurance card):

Last Name: _____ First Name: _____

Address: _____ DOB: _____/_____/_____

_____ Phone: _____-_____-_____

_____ Email: _____

Needs Interpreter? Y / N Language:_____

Reason for Referral:

Diagnosis/ICD: _____

Reason for Referral:_____

_____

_____

Documentation required (please fax/email with this form):

- ❑ Recent progress notes
- ❑ Relevant lab/pathology/imaging results
- ❑ Proof of insurance
- ❑ Authorization information (if required)

Allowing for holidays, patients will be called within 2 business days and seen within 5-10 business days.