Reset Form

Northwest Medical Group Referral Request

Thank you for referring your patient to Northwest Medical Group. Please have this form completed by the outside referring provider or their designee. **Once completed, kindly fax the form and medical records to 509-380-9591.**

Patient Name (LAST, FIRST, MI)		Date
Date of Birth	Patient Home Telephone	Patient Alternative Telephone
Patient Home Address		Patient-preferred language for healthcare communication
Patient LNI Insurance Coverage:		
Employer at the injury site:		Injured Address:
Date of Injury:		Claim Number:
Claim Manager:	Claim Manager Phone:	Claim Manager Fax:

Referral From:

Referring Provider Name (LAST, FIRST, MI)	NPI
Referring Provider Contact Telephone	Referring Provider Fax
Referring Provider Address	

Referral To:

☐ Transfer to Occupational Medicine
☐ Physical Therapy
☐ Occupational Therapy
☐ Massage Therapy
☐ Behavioral Health Interventions

Referral/Urgency

☐ Routine
☐ Urgent
☐ Emergent: referring Provider must call consulting Provider for emergent referrals

Reason for Referral:

☐ **Consultation** *(Diagnosis/Treatment/Surgical Opinion)*
☐ **Transfer of Care** *(Indicate condition or problem the specialist is being asked to manage)*

Reason for request; include diagnosis:

Provider Signature

Print Form Then Sign