Referral Request

Thank you for choosing Minnesota Care Counseling Services, INC
We look forward to parnering with you in your patient's care.

MNCCS REFERRAL CENTER
Phone: 612-353-4191
(Fax) 612-535-4647
(Fax) 1-800-933-0968
Email: mncarecounseling@gmail.com

Date: _____
pages: _____

☐ Routine
☐ Urgent

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____
Medical Group: _____
Phone: _____ Fax: _____ PCP: _____
Address: _____ City: _____ ZIP: _____
This form completed by: _____ Phone: _____

PATIENT INFORMATION (*Please provide copy of patient demographics/face sheet*):

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Phone: _____ Gender: ☐ Male ☐ Female
Patient's Address: _____
City/State/Zip: _____
Needs interpreter? ☐ Yes ☐ No Language: _____

REASON FOR REFERRAL:

Diagnosis/ICD: _____
Service/Specialty Requested: _____
Physician Requested: _____

☐ **Contact referring provider if requested physician is unavailable**

Type of Service Requested: ☐ Consultation ☐ 2nd Opinion ☐ Radiology Services ☐ Lab Services
☐ Follow up ☐ Surgery ☐ Other (please specify): _____
Reason for Referral: _____

DOCUMENTATION REQUIRED *(Please fax with this form)*:

- Recent/relevant typed clinical notes/test results, I.e. history & physical, MRI/Ct/X-rays results
- Proof of insurance
- Authorization information (*if required*)