MetroHealth

External Physician Referral Form

Phone 216-957-3222
Fax 216-778-2700

PLEASE PRINT ALL INFORMATION CLEARLY

Thank you for referring to the MetroHealth System.
Please provide the information below.
PLEASE WAIT 3 BUSINESS DAYS BEFORE CALLING FOR AN APPOITMENT

Date: _____
Printed Attending Provider's Name (First/Last): _____
NPI#: _____ Provider's Signature: _____
Referring Providers Phone & Fax #: _____
Facility Address, Zip Code: _____
_____

Patient: _____ SS#: _____
Phone: _____ Birthday: _____
Address: _____
Insurance Co: _____ ID#: _____
Group #: _____

**Specialty Dept / Procedure / Radiology (With or W/O Contrast) Requested:
_____

Specific Specialty Physician Requested (If applicable): _____
**Diagnosis/Reason for referral/ICD Code:
_____

Please forward your progress note with subjective and objective indications for the requested test. **

****Attach prior approval letter from insurance co. if needed****
** Make copies for future referral requests**