The MetroHealth System
2500 MetroHealth Drive
Cleveland, OH 44109
216-957-3222

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. We will send you a visit summary within 72 hours of the appointment.

Date: _____

Referring **Attending** Provider's Name (First and Last): _____

Provider's Signature: _____

Referring Provider Phone and Fax Number: _____

Facility: _____

Patient: _____

SS#: _____ Phone: _____

Birthday: ____ / ____ / ____

Address: _____

Insurance Company: _____ ID#: _____

Group #: _____

****Specialty Department/Procedure Requested:**

_____

Specific Specialty Physician Requested (if applicable): _____

****Diagnosis/Reason for Referral:**

_____

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

MAKE COPIES FOR FUTURE REFERRAL REQUEST