



**Routine Referral Worksheet
HMO ONLY**

**ROUTINE REFERRALS MUST BE FAXED TO (866) 529-0934
FOR URGENT REFERRALS, CALL (888) 681-7878**

Date: _____ **Requesting Physician:** _____

Form Completed By: _____

Phone Number (____) _____-____ **Fax Number** (____) _____-

Health Plan: Kaiser Permanente – Colorado Springs **PCP Name:** _____

Member #: _____

PATIENT: (Last Name) (First Name) **DOB** M____ F____

ADDRESS **CITY** **STATE** **ZIP CODE**

(____) _____-____
PATIENT PHONE

Provider/Specialty	Place of Service	# of visits
1. _____	_____	_____
2. _____	_____	_____

Code	Procedure Description	Date of Service
1. _____	_____	_____
2. _____	_____	_____

Preliminary Diagnosis:

ICD-9 Code: 1. _____ 2. _____ 3. _____

History/Medications/Treatment Rendered by PCP/Specialist: _____

Instructions to Member: _____
