PHYSICIANS' CLINIC
of Iowa, P.C.

REQUEST FOR CONSULTATION OR TRANSFER OF CARE

Please complete the form below and fax to the appropriate PCI specialty clinic:

Allergy	Fax: (877) 876-2384	Osteoporosis & Bone Health	Fax: (877) 303-8768
Audiology / Hearing Aids	Fax: (877) 876-2384	Physical Medicine & Rehabilitation	Fax: (877) 894-3629
Ear, Nose & Throat / Head & Neck Surgery	Fax: (877) 876-2384	Physical & Occupational Therapy	Fax: (319) 558-4062
Family Practice	Fax: (877) 781-3981	Plastic & Reconstructive Surgery	Fax: (877) 894-3629
Hematology & Oncology	Fax: (866) 274-5194	Rheumatology	Fax: (877) 725-3923
Internal Medicine (Health Transitions Clinic)	Fax: (877) 916-3091	Surgical Specialists	Fax: (877) 894-3629
Neurology & Sleep Medicine	Fax: (855) 428-0487	*(Cardiothoracic, General & Vascular Surgery)*	
Orthopaedics & Podiatry	Fax: (877) 303-8768	Urology	Fax: (888) 546-4251

REFERRING PROVIDER INFORMATION

Referring Provider Name _____ Date _____

Contact Name _____ Contact's Direct Phone Number _____

PATIENT INFORMATION

Date of Birth _____ Gender: ☐ Male ☐ Female

First Name _____ Last Name _____

Parent's Name *(if minor)* _____

Home Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Secondary Phone Number _____

Contact Instructions *(i.e. best time to reach, OK to leave a message, etc.)* _____

Emergency Contact Name _____ Emergency Contact Number _____

Insurance Plan Provider/Coverage _____

REQUESTED APPOINTMENT

☐ Urgent ☐ Routine

☐ Consultation—Request for opinion/advice. Diagnostic and/or therapeutic services may be initiated at the same or subsequent visits.

☐ Transfer of Care—Assume management of the patient problem(s) or medical condition(s).

Reason for referral, symptoms, and diagnosis *(please be specific and state the area of involvement)* _____

_____

_____

_____

Onset/Duration _____

Special Considerations *(i.e. hearing loss, language preference, etc.)* _____

Pertinent prior surgery or testing *(specify dates)* _____

_____

_____

_____

***Please send any pertinent lab or imaging results to Physicians' Clinic of Iowa.**

Specialty Requested _____ Provider Requested *(if any)* _____

☐ Patient has been contacted regarding the appointment.

Referring Provider Signature _____ Date _____

Referring Provider Printed Name _____

Thank you for allowing us to participate in caring for your patient. We will contact you regarding this referral within 48 hours.