Scottsdale Liberty HOSPITAL

17500 N Perimeter Dr
Scottsdale, AZ 85255
Tel: (480) 586-2300
Fax: (480) 452-1585

REFERRAL REQUEST FORM

Please fax completed referral form to (480) 452-1585

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Insurance: _____ Patient Phone: _____

Patient Email: _____ Date: _____

REFERRAL TYPE

- ❑ Consult
- ❑ Procedure: _____
- ❑ Other: _____

REFERRED PHYSICIAN OF CHOICE:

_____

REFERRAL SPECIALTY

- ❑ Pain Management
- ❑ ENT
- ❑ Gastroenterology
- ❑ Spine
- ❑ Orthopedic
- ❑ Podiatry
- ❑ General Surgery
- ❑ Bariatrics
- ❑ Gynecology
- ❑ Plastic Surgery

REFERRAL INFORMATION

Referring Provider: _____

Diagnosis: _____

Priority

❑Urgent (24 hours) ❑High (3-4 days) ❑Routine

Comments: _____

_____

_____

_____

PLEASE PROVIDE THE FOLLOWING INFORMATION

1. Patient demographics, copy of insurance card, and driver's license
2. The two most recent office notes
3. Applicable diagnostic tests
4. Recent history & physical

For Referral Request Form refills, please call (480) 586-2300.

*****Please verify for Out of Network benefits and choose a treating physician.*****