KAISER PERMANENTE®

Routine Referral Worksheet

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 #: _____

_____ _____ _____ M_____F_____
PATIENT: (Last Name) (First Name) DOB

_____ _____ _____ _____
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: _____
_____