Center For Clinical Resources
Western Maryland Health System
12502 Willowbrook Road (Medical Arts Center, Suite 300)
Cumberland, Md. 21502

Provider Referral Form

Patient's name: _____ Phone Number: _____

DOB:___/___/_____ Health Insurance (attach copy): _____ Primary Care Provider:_____

Address:_____

Diagnosis: _____ Duration: _____ **Ht: _____ Wt:_____**

Referred for the following services: ***Please send test results supporting diagnosis

☐ Diabetes Management * ***Includes NP, CDE, and Dietitian***	☐ Type I ☐ Type II ☐ Controlled ☐ Uncontrolled	☐ Gestational ☐ Pre-diabetes ☐ Other_____	☐ Oral agents ☐ Insulin _____ Fasting Glucose_____ A1C_____
☐ Diabetes Education*	☐ Group	☐ Individual	☐ CDE only
☐ Medical Nutrition Therapy (MNT)* ***Dietitian only***	☐ Diabetes ☐ Heart Failure	☐ COPD ☐ Renal ☐ Other:_____	
☐ Heart Failure Services* ***Includes medication titration and IV diuretic administration as indicated by patient presentation.***	**Indications:** ☐ NYHA class II-IV symptoms ☐ Documented LVEF of <45% ☐ Left ventricular systolic dysfunction (LVSD) ☐ Left ventricular diastolic dysfunction class II or worse, or class I with recent(within 60 days) hospitalization for volume overload ☐ Right sided heart failure ☐ Biventricular pacer placement due to cardiomyopathy ☐ ICD placement due to cardiomyopathy **For patients with none of the above additional criteria:** ☐ Refractory volume overload post-cardiothoracic surgery ☐ Readmission for heart failure <30 days following a heart failure admission		
☐ COPD Services* ***Education by Respiratory Therapist***	☐ Asthma ☐ Chronic Bronchitis ☐ Emphysema	☐ Pulmonary HTN ☐ Restrictive Lung Disease ☐ Occupational Lung Disease	☐ Thoracic Surgery ☐ Obesity/sleep apnea ☐ Other: _____
☐ Medication Therapy Management (MTM)	☐ Nonadherence ☐ Recent Transition of Care ☐ Multiple chronic disease states and/or medications		
Indicate any special needs:	☐ Vision ☐ Cognitive Impairment	☐ Hearing ☐ Language Limitations	☐ Physical ☐ Other_____

Referral made by: _____ Phone: _____

WMHS Inpatient location: _____Discharge date:_____ Outpatient Setting:_____

***Referring Provider Signature: _____Date:_____**

CONFIRMATION OF SCHEDULED APPOINTMENT: Center for Clinical Resources use only

Provider Name: _____ Appointment Date: _____ Appointment Time: _____

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Fax referral to: 240-964-8687 **For questions call: 240-964-8787**