Essentia Health

Referral to Essentia Health

Referring Physician Information

Referring Physician Name		Date *(mm-dd-yyyy)*
Practice Name		
Office Address		City
State	ZIP Code	NPI Number
Phone	Fax	

Patient Information

Patient Name *(First, Middle, Last)*		Sex ☐ Male ☐ Female	Birth Date *(mm-dd-yyyy)*
Address			
City	State		ZIP Code
Home Phone	Alternate Phone	■Mobile ☐Work ☐Other	Parent Name (if minor)
Maiden Name (optional)			

Referral Appointment Request

Reason for Referral. Submit any pertinent medical records.	
Scheduling Time Frame ☐ Routine Request (Next Available Appointment) ☐ Urgent Request (1-5 Business Days)	
Preferred Provider	Preferred Location
Indication or Diagnosis	
CPT Code	Specialty Department