REFERRAL TO
Specialty Care Free Clinic
1409 Emil Street, Madison, WI 53713
Phone: (608) 827-2308 Fax: (608) 827-2344

Date:___________________ **Specialty needed:**______________________________

Reason for Consult: ____

*****PLEASE ATTACH ALL MEDICAL INFO RELATED TO THIS CONSULT (i.e. Labs, Diagnostics, Current Medications, Procedures, Clinic Note)***

Referring Clinician:____ **Phone:** ________________

Clinic : ____ **Fax:** _________________

Address: ____________________________**City:** _________________________**Zip:** __________________

Patient Information

Name:____**Age:**____________ **DOB:**_________

Address:_____________________________________**City:**__________________________**Zip:**_________

Home#_________________________**Mobile#**_______________________ **Work#**_________________

Email Address: ____

Gender: **M** **F**

Race: **American Indian/Alaskan Native** **Asian** **Declined** **Multi Racial**

Native Hawaiian or Pacific Islander **Unavailable** **White/Caucasian**

Interpreter needed: **Yes** **No**

Language:__________________

Eligibility:

Is patient insured: **Yes** **No**

Physician Signature____**Date**_________________