WACBD
WASHINGTON CENTER FOR BLEEDING DISORDERS

REFERRAL FORM

Date: _____

1. **PATIENT NAME:** _____ DOB: _____

2. **REFERRAL URGENCY:** Routine ☐ Urgent ☐ (requires provider to call WACBD)

3. **UPCOMING PROCEDURES/SURGERIES:** _____

4. **REFERRAL TYPE:** Consultation ☐ Transfer of Care ☐

5. **SPECIFIC REASON/S FOR REFERRAL (include diagnosis if known):**

6. **REQUIRED DOCUMENTS:**

☐ Facesheet- demographics, contact info, preferred language, insurance

☐ Most recent and pertinent clinic notes, including hematology records if previously evaluated

☐ Most recent and pertinent lab results **(please include results from tests drawn day of referral)**

7. **REFERRING PROVIDER DETAILS:**

Provider Name: _____

Institution/Clinic: _____

Provider Phone: _____ Provider Fax: _____

Please FAX completed form and required documents to (206)614-1178.