Complete the following form to refer a patient to
Washington Center for Bleeding Disorders.

Please Note: Patient will not be scheduled until this form is completed and required medical records are received.

DATE: _____

1. **PATIENT DETAILS:** Attach the patient's Demographics, Phone/Email, Preferred Language, and Insurance Information.

2. **REFERRAL URGENCY:** _____Routine _____Urgent (**requires provider call to WACBD**)

3. **REFERRAL TYPE:** _____Consultation _____Transfer of Care

4. **SPECIFIC REASON/S for REFERRAL (include diagnosis if known):**

_____

_____

_____

_____

5. **REQUIRED DOCUMENTS FOR REFERRAL:**

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

_____ Most recent and pertinent lab results

6. **REFERRING PROVIDER DETAILS:**

Provider Name: _____ NPI#: _____

Institution/Clinic: _____

Provider Phone: _____ Provider Fax: _____

Modified/28Jan2022/JC