CONSULT/TRANSFER OF CARE REQUEST FORM

Please fax this form to Sanford Health Health Information Management at fax # 701-234-1435.

Family Healthcare Use for NDMA Only:

Referral Approved: _____ to _____

# of visits:_____

☐ Consult Includes Treatment

Patient Name:_____

Date of Birth:_____

Address:_____

_____

To:_____	From:_____
Department/Specialty:_____	Address:_____
Phone #:_____	Phone #:_____
Fax #:_____	Fax #:_____

Has the patient received any related services at another facility? ___Yes ___No

Choose only ONE

☐ Consult - Provide advice or opinion for treatment of this problem (treatment may be initiated).

PROBLEM:_____

☐ Transfer of Care

PROBLEM:_____

☐ Preop (Consult)

PROBLEM: (other than reason for surgery)_____

☐ Preop Clearance (no medical problems)

Appointment Requested: ___ Emergent ___ Urgent (< 3 days) ___ 4-14 days ___ Routine

Date:_____ **Time:**_____ **Provider Signature:**_____

NPI#_____