Essentia Health

Referral to Essentia Health

Referring Physician Information

Referring Physician Name			Date *(mm-dd-yyyy)*
Referring Facility 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

Last Revision: 11/27/2019