CHI Health Clinic

Nebraska Endocrinology
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Referral Request Form

(CHI Health Providers - do not use this form. Enter referral in EPIC.)

Name of Patient ________________________________ **Date of Birth** ________________

Patient Phone Number/Contact Information ___________________________________

Reason for Referral ____

Referring Provider ____

Referring Provider's Fax Number ____

*****Please fax below requested information to **402-875-7208**:

- **Completed referral form**
- **Office notes from the last year**
- **Labs from the last year**
- **Diagnostic testing**
- **Current medication list**
- **Demographic information and insurance cards**

Once received, the referral will be reviewed and our office will call the patient to schedule their initial visit.

***Please note, the referral will not be reviewed until ALL documents have been received. Thank you for your referral!**