UT Medicine
The University of Texas at Austin

Referral Form

UT Medicine (fax): 1-512-232-3899

Patient information

Name:
Address:

Preferred language:

DOB:
Day phone:
Alt. phone:

Insurance/authorization information

Insurance name:
Policy #:
Authorization # (if required):

Secondary insurance name:

Policy #:
Authorization #:

Referring physician information

Name of referring physician:
Address:

Phone:
Fax:
PCP:

Refer to provider and specialty

Referring to provider name:

Referring to specialty: Please Select One

Reason for referral (for oncology referrals please include diagnosis, stage and grade):

Primary/billing diagnosis:

Please send all pertinent records related to the care you are requesting

Clinical information/comment(s):