Guam Regional Medical City
Where Patients are Partners

REFERRAL FORM

GRMC REFERRAL FORM
TEL: (671) 633-GRMC (4762)
FAX: (671) 969-4874
EMAIL: refer@grmc.gu

PATIENT INFORMATION

NAME: _____ DOB: _____

PHONE #: _____ INSURANCE: _____

EMAIL ADDRESS: _____

REFERRAL INFORMATION

REFERRING PHYSICIAN: _____ ORGANIZATION: _____

PHONE #: _____ FAX #: _____

EMAIL ADDRESS: _____

Referral Priority: ○ **Routine** (next available date) ○ **Urgent** (less than 48 hours) Please call 671-645-5500 to have our operator connect you with a physician

Preferred Physician (If known): _____ **DIAGNOSIS/ICD-10:** _____

REASON FOR REFERRAL: _____

_____

CARDIOLOGY

☐ **CARDIOLOGY** ☐ **INTERVENTIONAL CARDIOLOGY** ☐ **HEART FAILURE CLINIC**

PROCEDURES: ○ Echo ○ Echo w/ Bubble Study ○ Echo w/ Lumason ○ Pacemaker Interrogation
○ Treadmill Stress Test ○ TEE ○ Zio Patch ○ Other _____

SURGERY

☐ **GENERAL SURGERY** PROCEDURES: ○ Dialysis Access ○ Endoscopy/Colonoscopy ○ Minimally Invasive/GI Surgery
○ Hernia ○ Other _____

CANCER

☐ **MEDICAL ONCOLOGY** ☐ **HEMATOLOGY** ☐ **INFUSION SERVICES** ☐ **RADIATION ONCOLOGY**

PROCEDURES: ○ Antibiotic ○ Blood Transfusion ○ Chemotherapy ○ Radiation ○ Other _____

NEUROSCIENCE

☐ **NEUROLOGY** ☐ **NEUROSURGERY** ☐ **NEURO & GENERAL INTERVENTIONAL RADIOLOGY**

PROCEDURES: ○ EEG ○ Home Sleep Test ○ Other _____

PULMONOLOGY

☐ **PULMONOLOGY**

PROCEDURES: ○ PFT ○ CPET ○ Methacholine Challenge ○ 6-Minute Walk Test ○ Airway Clearance
○ FENO ○ Bronchoscopy ○ Pulmonary Rehabilitation

REHABILITATION

☐ **REHABILITATION**

○ Physical Therapy ○ Speech Therapy ○ Occupational Therapy ○ Other _____

OTHER SPECIALTY PROVIDERS:

☐ **INFECTIOUS DISEASE** ☐ **ORTHOPEDICS** ☐ **PODIATRY** ☐ **SPORTS MEDICINE**

Comments: _____

REFERRING PHYSICIAN'S SIGNATURE: _____ **DATE:** _____