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) ◯ **STAT** (Immediately) Please call 671-633-GRMC (4762) 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 ◯ 6-Minute Walk Test
◯ Treadmill Stress Test ◯ TEE ◯ Zio Patch ◯ Other _____

SURGERY

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

CANCER CARE SERVICES AND INFUSION SERVICES

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

PROCEDURES: ◯ Blood Transfusion ◯ Chemotherapy ◯ Iron ◯ Radiation ◯ Other _____

Note: Providers referring for infusion or specialty drugs may be asked to complete screening recommendations.

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

☐ **PHYSICAL THERAPY** ☐ **OCCUPATIONAL THERAPY** ☐ **SPEECH LANGUAGE PATHOLOGY**
◯ Language Evaluation/Therapy ◯ Swallow Evaluation/Therapy

OTHER SPECIALTY PROVIDERS:

☐ **HYPERBARIC/WOUND CARE** ☐ **INFECTIOUS DISEASE** ☐ **ORTHOPEDICS** ☐ **PODIATRY** ☐ **RHEUMATOLOGY**
☐ **SPORTS MEDICINE**

Comments: _____

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

Note: Please send with patient's progress, pertinent diagnostic test results or procedures notes, and list of current medications.