MEDICAL REFERRAL FORM

LAKE OF THE WOODS COUNTY

SOCIAL SERVICE DEPARTMENT
218-634-2642
218-634-4520 (fax)

Amy Ballard Director
206 8th Avenue SE Suite 200
Baudette, MN 56623

DATE:	
PATIENT'S NAME:	
REFERRING PHYSICIAN:	
CLINIC NAME:	
ADDRESS:	
PHONE NUMBER:	
REFERRED TO: (Name, address and phone number of Doctor referred to)	
APPOINTMENT DATE & TIME:	

	YES	NO
IS THIS AN EMERGENCY REFERRAL?		
CAN THIS SERVICE BE PROVIDED WITHIN 30 MILES – PRIMARY CARE?		
CAN THIS SERVICE BE PROVIDED WITHIN 60 MILES – SPECIALTY CARE?		
IS THE PATIENT BEING REFERRED TO THE **NEAREST** MEDICAL FACILITY ABLE TO PROVIDE THE NEEDED CARE?		
IS THIS A MEDICALLY NECESSARY REFERRAL?		
IS THIS A PATIENT REQUESTED REFERRAL?		

+_____
SIGNATURE OF REFERRING PHYSICIAN OR NURSE

* RETURN COMPLETED FORM TO: JO AERY - OFFICE SUPPORT SPECIALIST *

OFFICE USE ONLY

CLIENT WAS NOTIFIED ON _____ THAT REFERRAL WAS APPROVED ☐ DENIED ☐

DENIALS -
COPY OF REFERRAL AND *YOUR APPEAL RIGHTS* (DHS-1941) WERE SENT ON_____.