

Please check the appropriate box, and fax to the office you are referring the patient to:

- | | | |
|--|-------------------|---------------------|
| <input type="checkbox"/> Behavioral Health Assessment Center | Fax: 913-789-3213 | Phone: 913-789-3218 |
| <input type="checkbox"/> Cancer Institute | Fax: 913-632-9159 | Phone: 913-632-9100 |
| <input type="checkbox"/> Cardiology* | Fax: 913-632-9444 | Phone: 913-632-9400 |
| <input type="checkbox"/> Cardiothoracic Surgery | Fax: 913-632-9447 | Phone: 913-632-9418 |
| <input type="checkbox"/> Endocrinology & Diabetes* | Fax: 913-676-8189 | Phone: 913-676-7585 |
| <input type="checkbox"/> Fertility | Fax: 913-780-4250 | Phone: 913-780-4300 |
| <input type="checkbox"/> General Surgery* | Fax: 913-632-9209 | Phone: 913-632-9200 |
| <input type="checkbox"/> Neurology* | Fax: 913-632-9828 | Phone: 913-632-9810 |
| <input type="checkbox"/> Neurology at Roeland Park
Multiple Sclerosis and Headaches Only | Fax: 913-632-2681 | Phone: 913-632-2680 |
| <input type="checkbox"/> Neurosurgery* | Fax: 913-632-9499 | Phone: 913-632-9480 |
| <input type="checkbox"/> Pulmonology* | Fax: 913-632-9799 | Phone: 913-632-9770 |
| <input type="checkbox"/> Whole Health Institute | Fax: 913-632-3559 | Phone: 913-632-3550 |

*Appointments available at multiple locations throughout the Kansas City metro.

Referring Provider: _____

Referring Provider Group: _____ Referring Provider Phone: _____

Patient First Name: _____ MI: _____ Last Name: _____

Patient Date of Birth: _____

Patient Phone: _____ Patient informed of referral: Yes No

Records to Include:

- Demographic information
- All office notes pertaining to the referral
- Labs
- Radiology report
- Procedure/operation notes
- Prior treatment

Comments: _____
