



**Referral to Mayo Clinic
Health System
Wisconsin**

(complete fields or place patient label here)

Patient Name <i>(First, Middle, Last)</i>	
Birth Date <i>(mm-dd-yyyy)</i>	Room Number <i>(if applicable)</i>
Mayo Clinic Number	



Form content retained in medical record.
Route to HIMS Scanning.

Select Location: Eau Claire La Crosse

Instructions: Print and fax completed document with any pertinent medical records including radiology imaging, and insurance card (back and front) to 855-392-9335 or 608-392-9814. To submit via phone, call 855-392-8400 or 608-392-9816.

Patient Information (Print/Do Not Use Label)

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address <i>(Street, City, State, ZIP Code)</i>	
Home Phone	Other Phone

Insurance Information

Subscriber Name <i>(First, Middle, Last)</i>	Subscriber Insurance Number
Insurance Plan Name	
Guarantor Name <i>(First, Middle, Last)</i>	Date <i>(mm-dd-yyyy)</i>
Guarantor Address <i>(Street, City, State, ZIP Code)</i>	

Appointment Request Information

Location Requested	Department Requested	Specialty Requested	Provider Requested
Appointment Timeline: <input type="checkbox"/> Urgent (less than 3 days) <input type="checkbox"/> 4-14 days <input type="checkbox"/> Routine <input type="checkbox"/> Other _____			
Chief Complaint (Diagnosis and ICD-10)			
Specific Tests Ordered: (ie, Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US)			

Referring Provider Information

Referring Facility Name			
Referring Provider Name <i>(First, Middle, Last)</i>		Person Completing Name <i>(First, Middle, Last)</i>	
Email	Phone for Questions	Fax	

Order Signature

Ordering Provider Signature ▶	Date <i>(mm-dd-yyyy)</i>	Time <i>(hh:mm 24-hour clock)</i>
Ordering Provider Printed Name <i>(First, Middle, Last)</i>		

