Complete and print.

Reset Form

MAYO CLINIC

Referral to Mayo Clinic Health System

Wisconsin

(complete fields or place patient label here)

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

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 1-855-392-9335 or 608-392-9814. To submit via phone, call 1-855-392-8400 or 608-392-9814.

Patient Information (Print/Do not use label)

Sex ☐ Male ☐ Female	
Address *(Street, City, State, ZIP Code)*	
Home Phone	Other Phone

Insurance Information

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

Appointment Request Information

Location Requested	Department Requested	Specialty Requested	Provider Requested
Appointment Timeline: ☐ Urgent (less than 3 days) ☐ 4–14 days ☐ Routine ☐ Other _____			
Chief Complaint (Diagnosis & ICD9)			
Specific Tests Ordered: (ie. Cardiac: Stress Echo, GXT Neuro: Sleep Study, EEG Radiology: MRI, CT, US)			

Referring Provider Information

Referring Facilty Name		
Referring Provider Name *(First, Middle, Last)*	Person Completing Name *(First, Middle, Last)*	
Email Address	Phone for Questions	Fax

Order Signature

Ordering Provider Signature ▶ Signature Required	Date *(mm-dd-yyyy)*	Time *(hh:mm 24-hour clock)*
Ordering Provider Printed Name *(First, Middle, Last)*		

Attention Mayo Clinic Staff
This form collects information that is not part of the medical record. **For local storage only.**

Print

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