REQUEST OF MEDICAL PROVIDER TRANSFER

Date of Request: ______________________________ **Received by:** _________________________

Patient Name: ____**D.O.B:**________________

Address: ____**Phone No.:** ____________________

Current Provider: _________________________ **Provider Requesting:** ________________________

Clinic Location Requested: (Circle) Colorado Parkhill Avondale

HIPAA or Guardianship form: (Please present) ____

Requestor Information: ____

☐ Check if same as patient

☐ Relationship (if other) ____

Reason for Request (Please Check)

☐ Location	☐ Gender
☐ Experience Level	☐ Communication
☐ Access	☐ Continuity
☐ Other	☐ Medication

Please Explain reason for request:

____

____

____

____

____

Name of Patient or Requestor (Print): ____

Name of Patient or Requestor Signature: ____

Denied: _______________________________ **Approved**: __________________________________

PLEASE ALLOW 2 WEEKS FOR REQUEST TO BE PROCESSED

Request sent to Dr. Reed______________________________

Comments: ____