broadlawns
MEDICAL CENTER

BMC Referral Form

SPECIALTY CLINIC REQUESTED / FAX

- ❑ Cardiology Clinic / (515) 282-2216
- ❑ Cityville Clinic / (515) 282-2419
- ❑ Dental Clinic / 515) 282-2774
- ❑ Dermatology Procedures / (515) 282-2332
- ❑ East University Clinic / (515) 282-5354
- ❑ Endocrinology Clinic / (515) 282-5447
- ❑ ENT Clinic / (515) 282-5734
- ❑ Family Health Center / (515) 282-2332
- ❑ Foot and Ankle Clinic / (515) 282-2515
- ❑ Geriatric & Memory Center / (515) 282-5705
- ❑ Gastroenterology / (515) 282-2332
- ❑ Healthy Lifestyle Living / (515) 282-2332
- ❑ Imaging Services / (515) 282-2266
- ❑ Infectious Disease Clinic / (515) 282-4540
- ❑ Internal Medicine / (515) 282-2520
- ❑ Mammography / (515) 282-5735
- ❑ Nephrology / (515) 282-6390
- ❑ Neurology Clinic / (515) 282-2346
- ❑ Oncology Center / (515) 282-6399
- ❑ Ophthalmology / (515) 282-5734
- ❑ Optometry / (515) 282-5734
- ❑ Orthopaedic Clinic / (515) 282-6382
- ❑ Outpatient Behavioral Health / (515) 282-5642
- ❑ Pain Management Center / (515) 282-8271
- ❑ Pediatric Clinic / (515) 282-2733
- ❑ Physical Therapy / (515) 282-3618
- ❑ Plastic Surgery / (515) 282-8283
- ❑ Primary Care Clinic / (515) 282-3708
- ❑ Pulmonary–Dr. Jason Wittmer / (515) 282-6390
- ❑ Sleep, Lung & Allergy Center / (515) 282-6235
- ❑ Surgery Clinic / (515) 282-6390
- ❑ Urology Center of Iowa at Broadlawns / (515) 282-7490
- ❑ Women's Health Center / (515) 282-7860

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____/_____/_____

❑ **Male** ❑ **Female** **Phone Number:** _____ **Alternate Phone:** _____

Street Address: _____ **City/State/Zip:** _____

Reason for request: ❑ **Interpreter Needed** **Language:** _____

REFERRING PROVIDER/GROUP

Referring Facility: _____ **Facility Phone Number:** _____

Email: _____ **Fax:** _____

Referring Provider: _____ **Provider Phone Number:** _____

Primary Provider: _____ **Provider Phone Number:** _____

NPI#: _____

REQUIRED INFORMATION

Insurance Carrier: _____ **Member ID:** _____

Insurance Authorization # (if applicable)**:** _____

All Relevant Tests/Labs/Diagnostic Studies: _____

Last Clinic Note, History and Physical: _____

Referrals may require additional phone calls if required information is not included.
Please fax this form and the required information to the specific clinic fax number listed above.

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Referral Form

D/MR-6336
64220 (09/19)rrh (01/20)rrh