Barlow
RESPIRATORY HOSPITAL

Refer a Patient

- Please FAX this form to **213-250-7415**
- Or contact our ADMISSIONS Team with any questions **213-202-6878**
- Please send a copy of the front and back of the insurance card
- Please **DO NOT** send medical records. If medical records are needed we will request them
- **PATIENT INFORMATION** (PLEASE PRINT)

Patient Name:		Birth Date:	CCF# / SS#:
Home Phone:		Work/Mobile Phone:	Gender: ☐ Male ☐ Female
Address:			
City:		State:	ZIP Code:
Marital Status:	Preferred Language:	Hearing or Visually Impaired: ☐ Hearing ☐ Visually	
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Declined		Race: ❏ American Indian/Alaska Native ❏ Asian ❏ Black ❏ White ❏ Native Hawaiian/Pacific Islander ❏ Multiracial/Multicultural ❏ Declined	
Emergency Contact Name:	Relationship to Patient:		Phone Number:
Insurance Name/Plan:		Group#:	Effective Date:
Subscriber Name:		ID#:	Subscriber Birth Date:
Primary Care Physician Name (Last, First):			

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name (Last, First):	Contact Name:	
Office Address:	Email Address:	
City:	State:	ZIP Code:
Phone Number:	Fax Number:	NPI Number:

MORE

Reason for referral (diagnosis or symptoms): DO NOT enter ICD codes here

QUESTIONS? Contact our Admissions Team, 24 hours a day, 7 days a week, at 213-202-6878
or toll free **833-4 BARLOW(833-422-7569)**.
Thank you for referring to Barlow Respiratory Hospital