SENECA
HEALTHCARE DISTRICT

REFERRAL FORM

Lake Almanor Clinic
199 Reynolds Road Chester, CA 96020
Phone: (530) 258-2882 Fax: (530) 258-2785

Referring physician: _____ Date: _____

Refer to: _____

Patient Name: _____ DOB: _____

Phone number: _____ Insurance: _____

Reason for referral/diagnosis: _____

_____

_____

Attach documents

Clinic note: ☐ Radiographic reports **WITH** Images: ☐ Lab reports: ☐ Medication lists: ☐

Other: _____

Internal Use Only Below This Line

Note date when attempt was made to make referral: _____

Referral completed by: _____ Date: _____

Date & time of appt: _____

Special instructions: _____

_____

_____

Patient notified on: _____ *Initial* _____