UW Medicine - Orthopedic Health & Sports Medicine Referral Request

Thank you for referring your patient to UW Medicine Orthopedic Health and Sports Medicine. This form is to be completed by the outside referring provider. For information about our services and locations please visit:
Orthopedic Health & Sports Medicine | Seattle, WA | UW Medicine.

If you have any questions about your referral, you can reach out to us directly at orthocare@uw.edu.
**To expedite the referral process, please attach all relevant medical records and imaging to this form.

Patient Information:

Patient Name (Last Name, First Name, Middle Initial)

Date of Birth

Patient's Preferred Language for Healthcare Communication

Patient Primary Telephone:

Patient Alternative Telephone:

Patient Insurance Provider and Plan

Referral From:

Referring Provider Name (Last / First / Middle Initial)

Telephone:

Fax:

Referring Practice Name and Address:

Referral To:

UW Medicine Specialty Clinic Name *(e.g., Hip & Knee Center at Meridian Pavilion):*

Clinic Location

Reason for Referral:

Urgency: Routine ◯ Urgent ◯ (please specify urgent needs in box below)

Diagnosis or Concern (please describe in box below)

Supporting Documentation (please indicate which documents are attached to this form)

Imaging (please specify below)

☐ MRI ☐ X- Ray ☐ CT Scan

☐ Ultrasound ☐ Medical Records ☐ Insurance Preauthorization

For UW Clinics to Complete
Current Referral Status:

☐ INCOMPLETE – awaiting documents
☐ UNDER MED REVIEW
☐ READY TO SCHEDULE
☐ SCHEDULED

Referring Provider signature
Print form then sign _____

UW Medicine