Referral to Mayo Clinic

Patient Type ☐ Domestic ☐ International

☐ **Rochester, Minnesota**			☐ **Phoenix/Scottsdale, Arizona**			☐ **Jacksonville, Florida**		
Phone	Domestic	800-533-1564	Phone	Domestic	866-629-6362	Phone	Domestic	800-634-1417
	International	507-284-8884		International	480-301-6539		International	904-953-7000
Fax	Domestic	800-321-1368	Fax	Domestic	480-301-4071	Fax	Domestic	904-953-0575
	International	507-538-7802		International	480-301-4071		International	904-953-7329

Referring Physician Information

Referring Physician Name		Date *(Month DD, YYYY)*
Practice Name	Referring Physician Email	
Office Address		City
State ***(Required for Domestic Patient)***	ZIP Code ***(Required for Domestic Patient)***	NPI Number ***(Required for Domestic Patient)***
Phone	Fax	Primary Care Physician (optional)

Patient Information

Mayo Clinic Number (optional)	Patient Name *(First, Middle, Last)*	Sex ☐ Male ☐ Female
Birth Date *(Month DD, YYYY)*	Patient Email (optional)	
Address		City
State ***(Required for Domestic Patient)***	ZIP Code ***(Required for Domestic Patient)***	Country (optional)
Home Phone	Alternate Phone ☐ Mobile ☐ Work ☐ Other	Parent Name (if minor)
Maiden Name (optional)	Spouse First Name (optional)	
Patient Insurance Information (if available)	Does the patient need an interpreter? ☐ Yes ☐ No	If yes, what language?

What is the request related to? ☐ Motor vehicle accident ☐ Litigation ☐ Workers' compensation ☐ Not applicable

Appointment Request

Clinical question to be answered. Submit any pertinent medical records.

Indication or Diagnosis

Specialty Requested

You will receive confirmation once the appointment is scheduled. To refer via our secure online portal, please visit www.mayoclinic.org/medicalprofs and click "Online Referrals." *Thank you for referring your patient to Mayo Clinic.*	Attention Mayo Clinic Staff This form collects information that is not part of the medical record. **For local storage only.**

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