



Physician Referral

at Alle-Kiski Medical Center

IF THIS IS AN EMERGENCY, CALL 911. DO NOT USE THIS FORM FOR EMERGENCIES.

Physician Resources

To refer one of your patients, you may call us at 1-866-680-0004 or complete this form to begin the patient referral process. A representative in your office will be contacted by one of our Referral Specialists to collect additional information. The patient will be contacted and the appointment confirmed.

Fax:
412-359-3002

or Mail:
Alle-Kiski Medical Center
1301 Carlisle Street
Natrona Heights, PA 15065
Attn: Physician Referral

or call us:
866-680-0004 • option 1 or
724-224-5100

About the referring physician

Name: * _____

Street: * _____

City/Town: _____

State: _____

Zip Code: _____

Office Phone: * _____

Office Fax: _____

Email: _____

About the patient

Name: * _____

Date of Birth: * _____

Gender: * Male Female _____

Street: _____

City/Town: _____

State: _____

Zip Code: _____

Daytime Phone: * _____

Evening Phone: _____

Fax: _____

Diagnosis information

Diagnosis Date: _____

Diagnosis Method:

- Biopsy
- Lab Work
- CT Scan
- MRI
- Ultrasound
- X-Ray
- Cytology
- Other (please specify):

General diagnosis information: *

Treatment information

Is the patient currently under treatment? *

- Yes No

If patient is currently under treatment, describe the method of treatment:

Referral information

Are you referring to a specific physician? *

- Yes No

If you are referring patient to a specific physician, provide physician's name: [\(find a physician online\)](#)

One of our Referral Specialists will call your office to discuss this referral further and to obtain additional information pertinent to this patient. Please indicate the contact person who can best assist with this referral.

About the referring physician

Same as physician information above?

- Yes No (if "no", please provide contact information below)

Name: _____

Title: _____

Daytime Phone/Ext: _____