

Referral Request Form

Primary Care Services, S.C. • 2500 S. Highland Ave., Suite 230, Lombard, IL 60148-7103
Phone (630) 429-9000 • Fax (630) 429-9060 • my-primarycare.com

Use this form to ask your Primary Care Services provider to consider a referral to a specialist or outpatient service. Your provider will review it and decide whether a referral is appropriate — completing this form does not create one.

Patient information

Patient name	Date of birth
Phone	Date of request
Primary care provider at PCS	MyChart / LiveWell username (if known)

Insurance

Insurance plan	Member ID
Does your plan require a referral? (yes / no / not sure)	Do you need prior authorization? (yes / no / not sure)

What you are requesting

Type of specialist or service (e.g. cardiology, physical therapy)	How soon do you feel you need to be seen?
Specific specialist or facility you prefer, if any	Preferred location
Reason for the request — what symptoms or condition is this about?	
How long has this been going on, and what have you already tried?	

Signature

I am asking my Primary Care Services provider to review this request. I understand a referral is not guaranteed and that my provider may ask me to be seen first.

Patient or representative signature	Date
If representative, relationship to patient	

How to submit this form and what happens next: Bring the completed form to the front desk at either Primary Care Services office. Your request is processed within three business days of the completed form being received, and you will be notified through the patient portal.

For office use only

Reviewed by	Date
Decision: approved / needs visit first / declined	Referral / order sent to
Authorization number (if applicable)	Patient notified (date / how)