6101 Frisco Square Boulevard
2nd Floor
Frisco, TX 75034
Phone: (469) 365-0772
Fax: (888) 977-6892
www.PACollin.org

PACC Referral Request Form

PART A: PHYSICIAN REQUESTING REFERRAL

Physician: ____ Specialty: ____

Address: ____

Contact Person: ___________________________________ Email: ____

Office Phone #: ___________________________________ Office Fax #: ____

PART B: PATIENT DEMOGRAPHICS

Name: ____ PACC ID #: ____

□ Male □ Female   Age: ______________________________ Date of Birth: _______________________________________

Address: ____ Apt: ________ City: ___________________ Zip: __________

Phone #:____________________________ Work #: ________________________ Other #: ________________________

PART C: SPECIALIST REQUIRED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed ___________________________________

Specialist Requested: ____

Please provide most recent H&P, lab report, and relevant diagnostic reports that applies to this visit.

PART D: DIAGNOSTIC PROCEDURE REQUESTED

Level of Urgency: □ 0-2 weeks □ 2-4 weeks □ When possible □ As directed ___________________________________

Diagnosis: ____

ICD-10 Code(s): ____

CPT Code(s): ____

Date of Surgery (if applicable): ___________________________ Time of Surgery (if applicable): ________________________

Facility: ____ Surgeon: __________________________ Anesthesia: □ yes □ no

Procedure(s): ____

Procedure Length: ________________________________ Special Needs/Requests: ________________________________

PHYSICIAN SIGNATURE ____ Date __________________________________

Please note: PACC patients can be referred to current physician volunteers only. Only medically necessary care will be provided through the PACC program, unless the resource is available. Elective procedures are not covered. For more information, please visit PACollin.org or call 469-365-0772.