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Appointment Line
Tel: 803-744-5958

REFERRAL FORM

Referral or Appointment
Fax: 803-744-0230

REFERRING PHYSICIAN INFORMATION					
Today's Date:					
Referring Physician:					NPI#:
Phone#:			Urgent <input type="checkbox"/> Non-Urgent <input type="checkbox"/>		
Preferred Physician <input type="checkbox"/>	First Available <input type="checkbox"/>	Physician Preferred:			
Contact Person:					
Dx:		Reason for Consult:			
Medical Records Sent: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Sent:		Sent Method: (Phone) (Fax) (Letter)	
FAX: 803-771-7422					
PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SS #:	Age:	Home #:		Work or Other #:	
Street Address:					
P.O. Box:	City:		State:	ZIP Code:	
INSURANCE INFORMATION					
Responsible Party:		DOB:	Address (if different):		Phone #:
Relationship:					
Primary Ins.:		Authorization:		Sec. Ins.:	Authorization:
Policy #:				Policy #:	

PLEASE INCLUDE MEDICAL RECORDS & INSURANCE CARDS WHEN FAXING REFERRAL
"WE WILL FAX THIS FORM BACK WITH APPOINTMENT TIME AND DATE BELOW"

FOR OUR OFFICE USE ONLY		
Fax To:	Appointment Date:	
Fax From:	Appointment Time:	
Fax #:	Appointment Made By:	
Date Faxed	Patient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	