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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: 803-744-0230				
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