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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#:		Fax#:		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 FAX: 803-744-0230		Date Sent:		Sent Method: (Phone) (Fax) (Letter)
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