Medical Centers
Surgical Clinic

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REFERRAL FORM

Referring Provider: _____

Referring Office Contact Name: _____ Date: ____ / ____ / _____

Referring Office Phone Number: _____ Referring Office Fax Number: _____

Patient Name: _____ DOB: ____ / ____ / _____

Patient Home Phone Number: _____ Patient Cell Phone Number: _____

Patient Insurance: _____ Referral Required? YES NO

Reason for Referral: _____

_____

Previous Imaging Done (ultrasound, CAT Scan, etc.) If yes, please specify: _____

_____

Please attach the following to this referral form:	**IMPORTANT:**
• Patient Demographic • ID and Insurance Card • Medication List • Diagnostic Test Results • Insurance Referral (if needed)	If the patient your office is referring needs are urgent, please call our office directly. Send referral after contacting us.

Thank you for your referral! We appreciate the opportunity to participate in your patient's care!

***** Once we have received your referral, we will fill out the section below and fax back to the fax number provided above *****

We have scheduled the following patient for: _____ / _____ / _____ Arrival Time: _____ am pm

Referral completed by: _____

Date Faxed to Referring Office: _____ / _____ / _____ Patient Aware of Appointment? YES NO