

PHYSICIAN SPECIALTY CLINIC REFERRAL FORM

Please select a specialty: General Surgery Wound Assessment Pulmonology

Physician preference: _____ or next available appointment

Patient's Name: _____

DOB: _____ Phone #: _____ Cell #: _____

Address: _____

Insurance Carrier: _____

Policy #: _____

1. Please describe the patient's chief complaint and *include onset and frequency*:

2. What is the key question you would like us to answer?

To expedite appointment scheduling, please provide the following by fax: (256) 417-4719

- This completed form Most recent office note
 Medical Records related to chief complaint
 Lab & test results within the last year
 Prior Authorization, or if not applicable, a copy of insurance card

Referring Provider: _____

Provider Address/Location: _____

Phone #: _____ Fax #: _____

Provider Signature: _____ **Date:** _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

Phone (256) 735-5900 Fax (256) 417-4719

If this is emergent, please contact our office directly.