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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 ❑ Non-Urgent ❑	
Preferred Physician ❑	First Available ❑	Physician Preferred:	
Contact Person:			
Dx:	Reason for Consult:		
Medical Records Sent: ❑ Yes ❑ No **FAX: 803-744-0230**	Date Sent:	Sent Method: (Phone) (Fax) (Letter)	

PATIENT INFORMATION				
Patient's Last Name:	First:	Middle:	Date of Birth:	Sex: ❑M ❑F
SS #:	Age:	Home #:	Work or Other #:	
Street Address:			E-mail:	
P.O. Box:	City:	State:	ZIP Code:	

INSURANCE INFORMATION			
Responsible Party: Relationship:	DOB:	Address (if different):	Phone #:
Primary Ins.: Policy #:	Authorization:	Sec. Ins.: Policy #:	Authorization:

PLEASE INCLUDE MEDICAL RECORDS & INSURANCE CARDS WHEN FAXING REFERRAL
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Fax #:	*Appointment Made By:*	
Date Faxed	*Patient Notified: ❑ Yes ❑ No*	