

Referral Center

Phone: _____

Fax: _____

Today's Date (MM/DD/YYYY): _____

1. Ordering Phys: _____ Attending Phys: _____

2. Patient Name: _____ Sex: _____ Age: _____

3. DOB: _____ Address: _____

4. Pt Phone Number: _____ Pt Work Number: _____

5. Insurance: _____

6. Referral Needed: _____

7. Reason(s) for Consult: _____

8. X-rays or tests already performed (Please include date and location Diagnostic Test):
_____ Date: _____ Location: _____ Breast Implants Yes
No

9. Urgency/Time: Routine _____ # of wks: _____ Urgent (STAT): _____

10. Time/Day of week Pt prefers: _____

11. Provider's Signature: _____

Doctor's Choice: _____ Patient Choice: _____ Availability: _____ Insurance: _____

For Referral Center Office Use Only

Appt Date: _____ Time: _____ am / pm Phone: _____

Person Spoke with: _____ Location: _____

Person Making Appt: _____ Fax: _____

Consulting Physician: _____ Facility: _____

Pre-certification/Referral #: _____

Dates Valid: _____ thru _____ Number of Visits: _____

Spoke with at Insurance company: _____ Number Called: _____

Notes: _____

Patient Notified by: Phone Voicemail Letter Date: _____ Time: _____ am / pm

Please attach the front and back of the Insurance Card and Driver's License. Please attach the completed Progress Note.