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.