HARDIN COUNTY GENERAL HOSPITAL & CLINIC
POB 2467, 6 Ferrell Road
Rosiclare, IL 62982
Phone: 618-285-6634 & 285-2800 FAX: 618-285-2007 & 285-2804

PATIENT REFERRAL FORM

When: **□ *ASAP* □ *Other:* _____**

Patient Name: _____ Date: _____Patient Account #_____

D.O.B. _____ S.S. #: _____ Allergies: _____

Parent's Name (if applicable): _____ Relationship: _____

Address: _____

Phone #: _____ Alternate Phone #: _____

Referring Physician/NP/PA: ☐ Sunga ☐ Chatto ☐ Hastie ☐ Frailey APRN ☐ Hicks APRN
☐ Spivey APRN ☐ Other: _____

Primary Physician: ☐ Sunga ☐ Chatto ☐ Hastie ☐ Frailey APRN ☐ Hicks APRN ☐ Spivey APRN
☐ Other: _____

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Procedure? **_____**

To what Provider: HCGH: □ Radiology □ Rehab □ OP Treatment Room □ Respiratory Therapy □ Ultrasound
□ Minor Surgery □ Dictician □ Social Services

Other: _____ Phone #: _____ FAX #: _____

Diagnosis or Symptoms (ICD-9 Code): **_____**

Provider Signature: **_____**

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Type of Pay: □ Medicare □ DPA □ Private □ CI *(make copy of front & back of card)* _____

Pre-certification needed? □ No □ Yes #: _____

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Appointment Date/Time: _____

Special instructions: ☐ Procedure/Prep Handout given to patient ☐ Other:_____
_____

_____

Date/Time Patient Notified : _____ By: _____

Healthcare Information attached: ☐ Medication ☐ H&P ☐ Other: _____

Referral Received _____ Records Faxed _____ Referral Completed _____

I hereby authorize payment of my insurance benefits directly to the hospital or physician. (Collection costs and attorney fees may be added to my account balance if it becomes delinquent.)

_____ _____ _____
Patient/Representative Signature **Date** **Clerks Initials**