# *REFERRAL REQUEST*

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**DATE:** _____

**REFERRING DOCTOR:** _____

**SPECIALTY:** _____ **NPI:** _____

**ADDRESS:** _____

**PHONE:** _____ **FAX:** _____

## REASON FOR CONSULTATION: _____

**PATIENT INFORMATION**

**NAME:** _____DOB:_____

**ADDRESS:** _____

**PHONE:** _____

## **PLEASE NOTE**

## APPOINTMENT WILL NOT BE MADE UNTIL THE FOLLOWING HAS BEEN RECEIVED BY OUR OFFICE:

- PATIENT DEMOGRAPHICS
- INSURANCE REFERRAL IF REQUIRED (MEDICAID PT 1ST, HEALTHSPRINGS, TRICARE PRIME ETC)
- OFFICE NOTES
- LAB SEROLOGY TO INCLUDE CULTURES, CBC, CMP, BMP, ESR, CR, ETC
- RADIOLOGY
- PATHOLOGY

ONCE ALL REQUIRED INFORMATION IS RECEIVED, WE WILL SCHEDULE THE APPOINTMENT AND FAX THIS FORM BACK TO YOU. **YOU WILL NEED TO NOTIFY THE PATIENT OF THIS APPOINTMENT**. WE WILL MAIL PAPERWORK TO THE PATIENT TO BE COMPLETED PRIOR TO APPOINTMENT.

## THE ABOVE REFERENCED PATIENT HAS BEEN SCHEDULED TO SEE

☐ **SCOTT PARKER, MD** ☐ **PAIGE SLATER, CRNP** **ON** _____ **AT** _____