



Healthcare Provider Referral / Consultation Request

PARTNERING FOR HEALTHIER, HAPPIER WOMEN



REFERRING PROVIDER INFORMATION

Date: ____ / ____ / ____

Referring Provider: _____

Practice / Facility: _____

NPI: _____

Phone Number: (____) _____

Fax Number: (____) _____

Email: _____



PATIENT INFORMATION

Referral Date: ____ / ____ / ____

Full Name: _____

Date of Birth: ____ / ____ / ____

Phone Number: (____) _____

Email: _____

Address: _____

Insurance Company: _____

Member ID: _____

Group Number: _____

☐ Commercial Insurance ☐ Self-Pay ☐ Other: _____



SERVICE REQUESTED

- ☐ Primary Care
- ☐ Women's Health
- ☐ Annual Preventive Visit
- ☐ Problem Visit
- ☐ Menopause / HRT

- ☐ Birth Control / Contraception
- ☐ PCOS / Abnormal Bleeding
- ☐ STI / Vaginitis Evaluation
- ☐ Medical Weight Loss
- ☐ Telehealth Visit

- ☐ Mental Health Evaluation / Referral
- ☐ Procedure
- ☐ Other: _____



REASON FOR REFERRAL / DIAGNOSIS

ICD-10 Code: _____



URGENCY / SCHEDULING PRIORITY

- ☐ Routine
- ☐ Within 7 Days
- ☐ Within 48 - 72 Hours
- ☐ First Available



PREFERRED VISIT TYPE / LOCATION

- ☐ In-Person: Atlanta / Vinings
- ☐ Telehealth
- ☐ No Preference



PLEASE ATTACH (if available)

- ☐ Demographics / Facesheet
- ☐ Recent Office Note(s)
- ☐ Medication List
- ☐ Front and Back of Insurance Card
- ☐ Relevant Labs
- ☐ Other Records: _____
- ☐ Imaging / Reports



24/7 Scheduling:
1-800-577-3929



Website:
thethrivelife.net



Email:
patient.support@thrivewomenprimarycare.com

Please fax referral form and supporting records for review.



WOMEN THRIVE HERE.

TOGETHER
FOR A HEALTHIER TOMORROW 