PLEASE COMPLETE AND RETURN
DIABETES & ENDOCRINE WELLNESS CENTER, LLC

1 Hospital Drive SW, Suite 300 Huntsville, AL 35801 P: 256-881-2700 F: 256-429-9109

ATTENTION: Patient WILL NOT be scheduled without ALL the requested forms. After we receive the referral information in its entirety, we will contact the patient directly to schedule an appointment. Please allow 5-7 days for this process. Please ask your patients to wait for a call from our office. We thank you in advance for your help.

***COMPLETED REFERRAL FORM**
***PHYSICIAN PROGESS NOTES**
***CURRENT MEDICATION LIST**
***COPY OF DRIVER'S LICENSE AND INSURANCE CARD (OR LEGIBLE PRINTOUT)**
***CURRENT LABS (A1C FOR DIABETICS; TSH, FT4 FOR PATIENTS WITH HYPO or HYPERTHYROIDISM)**
***TRICARE, UNITED HEALTHCARE AND BCBS REFERRALS IF REQUIRED**
***MEDICAID PATIENT FIRST REFERRAL**

Please use this form as your cover sheet.

PATIENT INFORMATION	REFERRING PHYSICIAN INFORMATION
Patient Name: _____	Practice Name: _____
☐ Male ☐ Female Age: _____ DOB: _____	Physician Name: _____
Home Phone: _____	Specialty/Area of Practice: _____
Cell Phone: _____	CRNP Name: _____
Address: _____	Address: _____
City, State, Zip:_____	City, State, Zip: _____
Primary Insurance:_____Group#:_____	Street Address: _____
Policy# _____	Office Phone: _____
Secondary Insurance:_____ Group#:_____	Office Fax: _____
Policy#:_____	NPI #: _____
Tricare, Medicaid, BCBS Referral Attached: ☐ YES ☐ NO	Reason for Consultation: _____
Race: _____ Ethnicity: _____	_____
Primary Language Spoken: _____	

Referring Provider's Signature: _____Date:_____