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**Appointment Line**  
**Tel: 803-744-5958**

**REFERRAL FORM**

**Referral or Appointment**  
**Fax: 803-744-0230**

REFERRING PHYSICIAN INFORMATION				
Today's Date:				
Referring Physician:				NPI#:
Phone#:			Urgent <input type="checkbox"/> Non-Urgent <input type="checkbox"/>	
Preferred Physician <input type="checkbox"/>	First Available <input type="checkbox"/>	Physician Preferred:		
Contact Person:				
Dx:		Reason for Consult:		
Medical Records Sent: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>FAX: 803-771-7422</b>		Date Sent:	Sent Method: (Phone) (Fax) (Letter)	
PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	Date of Birth:
				Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SS #:	Age:	Home #:		Work or Other #:
Street Address:				
P.O. Box:	City:		State:	ZIP Code:
INSURANCE INFORMATION				
Responsible Party:		DOB:	Address (if different):	
Relationship:				Phone #:
Primary Ins.:		Authorization:		Sec. Ins.:
Policy #:				Authorization:
				Policy #:

**PLEASE INCLUDE MEDICAL RECORDS & INSURANCE CARDS WHEN FAXING REFERRAL**  
**"WE WILL FAX THIS FORM BACK WITH APPOINTMENT TIME AND DATE BELOW"**

FOR OUR OFFICE USE ONLY		
Fax To:	Appointment Date:	
Fax From:	Appointment Time:	
Fax #:	Appointment Made By:	
Date Faxed	Patient Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	