

REFERRING PHYSICIAN FORM

4539 Hedgemore Drive, Charlotte NC 28209:::Phone # (704) 331-9669:::Fax# (704) 688-0035

PATIENT INFORMATION

Patient's Name _____ DOB _____

Address Line 1 _____ Address Line 2 _____

City _____ St _____ Zip _____

Phone #-Home _____ Cell _____ Work _____

Insurance Plan Name(s): _____

Policy # _____ Group# _____

1) Is the insurance *Medicaid Carolina Access*? Y or N 2) Is the insurance *Workers Comp*? Y or N

Reason for consultation/ referral _____

REFERRING PHYSICIAN INFORMATION

Referring Physician Name _____ NPI# _____

Practice Name _____ Location _____ Main Phone _____

Name of Contact Person At Your Office _____

Contact Person's Direct Phone # _____ Fax # _____

Patient was last seen in your office on: _____

Has patient been notified of being referred to our office? _____

PLEASE FAX THIS COMPLETED FORM to Fax # (704) 688-0035 along with:

Copy of medical records, including most recent office visit note, labs, cultures, x-rays, or anything else pertinent to patient's condition.

Copy of insurance card (front and back)--please enlarge card if possible.

***Once the above information is received, we will call the patient to notify of the appointment date and time and will fax it to you as well. Thank you very much! Much information the patient needs about our office can be accessed at:**

www.idconsultants.org