



Please complete ALL information listed below to help us process this referral and expedite treatment to your patient.

Name of Referring Practice: Physician:

Contact Person: Phone: Fax#:

Patient Information

Patient's Name: DOB: Gender:

Address: City: State Zip Code

Home Phone: Cell Phone: Email Address:

Parents/Guardian's Name: Parents' DOB Relationship:

Interpreter Needed Type: Spanish Hearing Impaired Other:

Insurance Information - Please include front and back copies of the patient's card

Primary Insurance:

Subscriber's Name: DOB: Policy #: Group#:

Authorization/NPI#: # of Visits: Effective Dates: to

Secondary Insurance:

Subscriber's Name: DOB: Policy#: Group#:

Authorization/NPI#: # of Visits: Effective Dates: to

Symptoms:

Locations & Physicians

Table with 8 columns: Locations, First Available, and six Physician names (Herring, Hungness, Norris, Roberts, Seiler, Silton). Rows list various locations like Eastover, Ballantyne, Concord, etc.

If you have not received a response to this fax in 5 business days please contact our physician priority line at 704-998-0965

We will send you an appointment confirmation sheet back after we have tried to contact your patient.

If you prefer, you may send referrals directly from your Electronic Health Record System as we are participating in the Health Information Systems Program.