



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

Locations	First Available	Physicians					
		Herring	Hungness	Norris	Roberts	Seiler	Silton
Eastover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ballantyne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concord	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lake Norman	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Monroe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Rock Hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
SouthPark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
University	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uptown	<input type="checkbox"/>						
Waverly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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.