

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: (Most beneficial to contact patient) _____

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	Available Physicians					
Eastover	<input type="checkbox"/> Caicedo	<input type="checkbox"/> Herring	<input type="checkbox"/> Hungness	<input type="checkbox"/> Norris	<input type="checkbox"/> Roberts	<input type="checkbox"/> Silton
Ballantyne	<input type="checkbox"/> Chadha	<input type="checkbox"/> Collins	<input type="checkbox"/> Errington	<input type="checkbox"/> Patel, RR	<input type="checkbox"/> Silton	
Concord	<input type="checkbox"/> Collins	<input type="checkbox"/> Errington	<input type="checkbox"/> Herring	<input type="checkbox"/> Patel, RR		
Cornelius	<input type="checkbox"/> Gilchrist	<input type="checkbox"/> Norris				
Gastonia	<input type="checkbox"/> Langley	<input type="checkbox"/> Roberts	<input type="checkbox"/> Silton	<input type="checkbox"/> Patel, VK		
Hickory	<input type="checkbox"/> Sran					
Huntersville	<input type="checkbox"/> Herring	<input type="checkbox"/> Lemke				
Matthews	<input type="checkbox"/> Caicedo	<input type="checkbox"/> Patel, VK	<input type="checkbox"/> Durban (Dietician)			
Monroe	<input type="checkbox"/> Chadha	<input type="checkbox"/> Collins	<input type="checkbox"/> Collura			
Mooresville	<input type="checkbox"/> Gilchrist	<input type="checkbox"/> Lemke				
Rock Hill	<input type="checkbox"/> Chadha	<input type="checkbox"/> Errington	<input type="checkbox"/> Hungness	<input type="checkbox"/> Patel, RR		
SouthPark	<input type="checkbox"/> Chadha	<input type="checkbox"/> Collins	<input type="checkbox"/> Hungness	<input type="checkbox"/> Langley	<input type="checkbox"/> Patel, VK	<input type="checkbox"/> Durban (Dietitian)
University	<input type="checkbox"/> Caicedo	<input type="checkbox"/> Langley	<input type="checkbox"/> Norris	<input type="checkbox"/> Roberts		
Waverly	<input type="checkbox"/> Caicedo	<input type="checkbox"/> Collura	<input type="checkbox"/> Patel, RR			

From the grid above, indicate below the Location and the Physician preference...

Location	Physician

Our Referrals/Physician Priority Line: 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.