New Patient Referral Information Form
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*******FORM TO BE COMPLETED BY PHYSICIANS ONLY*******

Office Use Only	Referring Physician Information
Date Received	Date: ____________ Contact Person: ____________
	Referring Physician ____________
Via	Phone Fax
Fax Mail	**Patients Medical Records Included**
	☐ Visit Notes ☐ Insurance Authorizations
	☐ Labs ☐ Medical History
	☐ Scans/Ultrasounds ☐ Problem List
	☐ Medication List ☐ Other ____________
	In order to expedite the process we require Patient Medical Records are forwarded with this request. This is to include recent visit notes, labs, and all medication that the patient is currently on.

Triage	Reason for Referral *Please circle appropriate reason or specify under other.*			
Info Entered — Yes / No	Endocrinology Gen.	Thyroid	Diabetes	Osteopenia
Date	PCOS	Amenorrhea	Addison's	Osteoporosis
	Obesity	Fatigue	Cushing's	Weight Gain
	Other *(Specify)* ____________			

Scheduling	Patient Information *Please complete all fields or enter n/a for not applicable*
Appt Info Date Time	Last Name ____________ First Name ____________ Mi ______
	DOB ____________ Gender M F
Appt With	SS No. ____________
Physician ARNP	Address ____________
Completed by	City ____________ State ______ Zip ______
	Home No. Work No.

Verification	Patient Insurance Information		
Coverage Y / N		**Primary**	**Secondary**
Date	Insurance Carrier		
	Identification No.		
Policy Holder	Group		
Patient Other	Ins. Contact No.		
Copay	Authorization No.		
Deductible	Exp. Date		

Medical Records	Primary Physician Information *Please fill out completely if different from Referring Physician Information*
PT Records Received — Yes / No	Primary Physician ____________
Date	Phone Fax