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## **NEW PATIENT REFERAL FORM**

### Patient information:

- Name: \_\_\_\_\_
- DOB: \_\_\_\_\_
- Age: \_\_\_\_\_
- Gender: \_\_\_\_\_
- Address: \_\_\_\_\_
- Best contact phone numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

### Insurance Information: (copy and fax both sides of the card)

- Insurance provider: \_\_\_\_\_
- Policy holder's name: \_\_\_\_\_
- Policy holder's DOB: \_\_\_\_\_
- Policy number: \_\_\_\_\_
- Group number: \_\_\_\_\_
- Expiration date: \_\_\_\_\_
- Medicaid referral authorization number (if applicable): \_\_\_\_\_

### Referral information:

- Consultant requested: Dr. George Wadie, MD, Carolina Pilonidal Center
- Reason for referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Referring provider information:

- Name of the provider: \_\_\_\_\_
- Name of the practice: \_\_\_\_\_
- Office phone: \_\_\_\_\_
- Office fax: \_\_\_\_\_
- Best contact person (referral coordinator): \_\_\_\_\_

### Fax the following information along with this form:

- Copy of insurance card – both sides
- Clinical records: office visits, investigations (labs and radiology) and growth chart.