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General Surgery & Bariatric Surgery

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NEW PATIENT REFERRAL FORM

Patient:____

Patient's DOB:_________ Age___________ Male___________ Female____________

Patient Address:____

Patient Contact Number: Home________________________Cell____________________________

Reason for Referral:____

Referring Physician:____ NPI_____________________

Referring Contact Name:______________________________Phone number_____________________

Primary Insurance:________________________Contract#___________________Group#__________

Secondary Insurance:______________________Contract#___________________Group#__________

REQUIRED DOCUMENTS

Please send updated office notes as well as the following:

Referral for breast	Mammogram/and or ultrasound reports
Referral for gallbladder	Abdominal ultrasound, HIDA scan, CT scan reports
Referral for bariatric surgery	Five years of medical records documenting weights (1 per year)
Referral for hernia	CT scan reports
All other referrals	Radiology reports, labs, path reports if applicable

Once the above documents are received, we will call the patient to schedule an appointment. **If utmost urgency is required, please call our office at 256-736-2263 for immediate assistance.** We appreciate your referral.