LAUREL ENDOCRINE & Thyroid Specialists, PA

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PLEASE PRINT AND COMPLETE ALL FIELDS

DATE: _____REFER TO: _____

NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

SEX: _____ RACE: _____ LANGUAGE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____EXT:_____

SOCIAL SECURITY NUMBER: _____

HEALTH INSURANCE COMPANY: _____

INSURANCE ID # _____2nd INSURANCE _____

AUTHORIZATION NUMBER: _____

ATTENTION

1. PLEASE FAX LABS, OFFICE NOTES, COPY OF INSURANCE CARD, AND AUTHORIZATION.
2. PLEASE INFORM PATIENT TO BRING ACTUAL FILMS TO THEIR APPOINTMENT.
3. PLEASE ALLOW 2-3 DAYS FOR APPOINTMENT.

YOUR OFFICE WILL BE NOTIFIED BY FAX AND PATIENT BY PHONE/MAIL WHEN APPOINTMENT IS SCHEDULED.

CLINICAL INFORMATION: ***All referrals over 20 pages should be mailed to our address.***

REFERRING PHYSICIAN: _____

OFFICE ADDRESS: _____

CONTACT PERSON_____NPI#_____

TELEPHONE#_____FAX#_____

CONSULT REASON: _____

IS THE PATIENT PREGNANT? YES/NO EDD? _____

___ PATIENT HAS BEEN NOTIFIED OF DIAGNOSIS ___ ATTEMPTED TO REACH PATIENT BUT COULD NOT REACH

Please send the records that are relevant to the diagnosis only.

Thank you for your kind referral to Laurel Endocrine and Thyroid Specialists, PA