



REFERRAL FORM

For questions, please call 704-371-4740

DATE: _____

Patient Name _____

Social Security or PRO Number _____ Date of Birth: _____

Address _____
City State Zip

Phone Numbers _____
Home Work Cell

Reason for Referral: (Circle the one that applies)

Send form to:

1 Physician Office Consultation Referral:

This patient is enrolled in Physicians Reach Out and needs a specialty consultation.

Fax: (704) 943-3747

Specialist (Type) _____

Reason for Specialist: _____

Expedite: Y/N Time-frame recommended: _____

2 Physician Office Eligibility Referral:

If you have uninsured patients who may qualify for Physicians Reach Out, please have them call PRO at 704-371-4740 to learn how and when to apply. Please do not send referrals until the patients are enrolled in the program. Thank you very much for your assistance.

Have patient call 704-371-4740

Recommendations/ Additional Comments: _____

Practice Name: _____ Referring Physician: _____

Practice Address: _____

Practice Phone: _____ Practice Fax: _____

Practice Nurse/ Case Mgr. Or Other Contact: _____

For Physicians Reach Out Use

Appointment Made with: _____ Practice: _____

Date: _____ Time: _____ Location: _____

PLEASE FAX MEDICAL RECORDS TO:

