

SPECIALTY REFERRAL

Fax to Centralized Scheduling at (606) 408-8908
or call 1-877-304-1935



Patient Name: _____ Date of Referral: _____
Date of Birth: _____ Social Security Number: _____
Street Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Alternate Phone: _____
Email: _____

INSURANCE INFORMATION *Please include a copy of the patient's insurance card(s).*

Policyholder's Name: _____
Relationship to Patient: Self Spouse Parent Child Other: _____
Policyholder's DOB: _____ Primary Phone #: _____
Primary Insurer: _____ Policy # _____ Group # _____ Effective Date: _____
Secondary Insurer: _____ Policy # _____ Group # _____ Effective Date: _____
Primary Diagnosis: _____ ICD-10 Code: _____

REFERRAL TO:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIMS (Advanced Illness Management) | <input type="checkbox"/> General Surgery* | <input type="checkbox"/> Physical Therapy* |
| <input type="checkbox"/> Allergy Services | <input type="checkbox"/> Gynecology* | <input type="checkbox"/> Physical Therapy (Pediatric) |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Headache Clinic | <input type="checkbox"/> Plastic/Reconstructive Surgery* |
| <input type="checkbox"/> Behavioral Health (Outpatient) | <input type="checkbox"/> Heart Failure Clinic* | <input type="checkbox"/> Podiatry* |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Home Health | <input type="checkbox"/> Pulmonology* |
| <input type="checkbox"/> Cardiology* | <input type="checkbox"/> Hypertension Clinic* | <input type="checkbox"/> Pulmonology (Pediatric) |
| <input type="checkbox"/> Cardiology/Electrophysiology* | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology/Structural Heart | <input type="checkbox"/> Infusion Center* | <input type="checkbox"/> Short-Term Rehab |
| <input type="checkbox"/> Cardiothoracic Surgery | <input type="checkbox"/> Interventional Radiology | <input type="checkbox"/> Speech Therapy* |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Interventional Spine/Pain Mgmt | <input type="checkbox"/> Speech Therapy (Pediatric) |
| <input type="checkbox"/> Colorectal Surgery | <input type="checkbox"/> Lipid Clinic | <input type="checkbox"/> Sports Medicine* |
| <input type="checkbox"/> Coumadin Clinic* | <input type="checkbox"/> Nephrology* | <input type="checkbox"/> Urology* |
| <input type="checkbox"/> COVID Infusion | <input type="checkbox"/> Neurology | <input type="checkbox"/> Urology (Pediatric) |
| <input type="checkbox"/> Dermatology* | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Vascular Surgery* |
| <input type="checkbox"/> Diabetes Education* | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Weight Loss, medical |
| <input type="checkbox"/> Dietetics* | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Weight Loss, surgical |
| <input type="checkbox"/> ENT/Otolaryngology* | <input type="checkbox"/> Occupational Therapy* | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Occupational Therapy (Pediatric) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Epilepsy Clinic* | <input type="checkbox"/> Oncology/Hematology* | |
| <input type="checkbox"/> Family Practice/Primary Care* | <input type="checkbox"/> Orthopedics/Sports Medicine* | |
| <input type="checkbox"/> Gastroenterology* | <input type="checkbox"/> Pediatrics* | |

* - Available in multiple locations

Please indicate provider/location preference, if applicable: _____

Referring Provider's Printed Name: _____

Phone #: _____ Fax #: _____

Provider Signature: _____ Date & Time: _____