COLON AND RECTAL CLINIC OF ORLANDO

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REFERRAL REQUEST FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form to our office. If you have any questions, please call our office and ask for Jahvonda, our New Patient Coordinator.

Referring Provider Information

Referred by (MD): _____ Medical Group:_____

Phone: _____-_____-_____ Fax:_____-_____-_____ PCP:_____

Address: _____ City: _____Zip_____

This form completed by: _____ Date: _____ Phone: ____-_____-_____

Patient Information *(Please provide copy of patient demographics/face sheet)*

Last Name:_____ First Name_____ MI _____

DOB_____ Gender: Male/Female Phone: _____-_____-_____

Patient's Address:_____

City/State/Zip: _____ Needs Interpreter? Y / N Language:_____

Reason for Referral

Diagnosis/ICD _____

Service/Specialty Requested:_____ Physician Requested: _____

Type of Service Requested: ☐Consultation ☐2nd Opinion ☐Radiology Services ☐Lab Services
☐Follow up ☐Surgery ☐Other *(please specify):* _____

Reason for Referral:_____

_____

_____

Documentation Required *(please fax with this form)*

- ☐ Recent/relevant typed clinical notes/test results, i.e. History & Physical, Labs, CT/X-rays results
- ☐ Proof of Insurance
- ☐ Authorization information (if required)

This form can be downloaded at http://www.crcorlando.com/