Endocrinology Division
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FAX REFERRAL FORM
Fax#: 910-341-1900

Patient Name:_____

DOB:_____/_____/_____SS #:_____-_____-_____Phone#:(H)_____(W)_____

Address:_____

Referring MD:_____Phone #:_____Fax #:_____

Patient's PCP:_____Phone #:_____

Insurance Co:_____Phone #:_____

Authorization #:_____Phone #:_____

Subscriber's Name:_____ID #:_____

Group #:_____Employers Name:_____

Reason for Referral:_____

In an effort to accommodate all referrals quickly, it is our policy to offer the first available appointment.

Please indicate specific physician—if REQUIRED:_____

*****PATIENT'S MOST RECENT LABS, OFFICE NOTES, RADIOLOGY AND COPY OF THE FRONT & BACK OF THE INSURANCE CARD MUST BE FAXED TO 910-341-1900 BEFORE THE REFERRAL WILL BE COMPLETED*****

*****Referrals sent to any other fax number will not be processed*****

Any questions please call 910-772-5943 or 910-772-5953.