Wilmington Health Patient Referral Form

Phone: 910-341-3300 Fax: 910-341-1900

Please check the box for the requested department for referral:

- ☐ Audiology
- ☐ Bariatric Surgery
- ☐ Cardiology
- ☐ Colorectal Surgery
- ☐ Dermatology
- ☐ Ear, Nose and Throat
- ☐ Endocrinology
- ☐ Foot and Ankle
- ☐ Gastroenterology
- ☐ General Surgery
- ☐ Neurology
- ☐ Infectious Disease
- ☐ Nutrition and Diabetes Management
- ☐ Oncology
- ☐ Orthopaedics and Sports Medicine
- ☐ Plastic and Reconstructive Surgery
- ☐ Pulmonary
- ☐ Rheumatology
- ☐ Sleep Medicine
- ☐ Urology
- ☐ Urogynecology
- ☐ Vascular Surgery

Patient Name: _____

Sex_____ DOB:_____/_____/_____ SS #:_____-_____-_____

Phone#: (Home)_____(Work/Cell)_____

Address:_____

Referring MD:_____Phone #:_____ Fax #:_____

Address:_____ NPI:_____

Insurance Co:_____

Primary:_____ Secondary:_____

Authorization Required: Yes No Authorization #:_____Contact #_____

ID #:_____ Group #: _____

Subscriber's Name:_____ Employer's Name:_____

Subscriber's DOB:_____/_____/_____ Subscriber's SS #:_____-_____-_____

Reason for Referral:_____

Referring to:_____ or, first available provider

Urgency of Request: 1st Available 1-2 Days 1-2 weeks Other (specify):_____

Please fax ALL related medical records including:

- Last 3 office notes (including history and physical)
- Insurance Cards (front and back) - Please note: Authorizations for Visits must be sent along with referral for Tricare Prime or HMO Policyholders.

Pertinent records to condition:

- Diagnostic imaging reports (If chest Imaging: please send report and disc of images.)
- Labs, cultures, pathology reports
- Diagnostic orders with CPT code and diagnosis clearly noted; also including insurance authorization
- Operative reports (if applicable)
- Cardiology Referrals: Picture of EKG, labs, previous Echos, and EKG reports
- Medication List; including drug allergies (if applicable)

Thank you for choosing WH to serve your patient(s). Confirmation: Your patient was contacted and appointment confirmed: Date: ____/____/____ Time: _____ with _____