Carolinas HealthCare System

REFERRING PHYSICIAN FORM

PATIENT INFORMATION

Patient's Name:_____ DOB:_____

Address _____

City_____ State_____ Zip_____

Phone _____(h) _____(c) _____(w)

Insurance Plan _____

Policy # _____ Group# _____

1) Is the insurance *Medicaid Carolina Access*? **Y or N** 2) Is the insurance *Workers Comp*? **Y or N**

Reason for consultation/referral _____

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name: _____ NPI# _____

Practice Name: _____

Location: _____Phone: _____

Direct Contact Name: _____

Direct Contact Phone: _____ Direct Contact Fax: _____

Patient was last seen in your office on: _____

Has patient been notified of being referred to our office? _____

PLEASE FAX THIS COMPLETED FORM TO FAX # 704-688-0035 ALONG WITH:

__ Copy of medical records, including most recent office visit notes, labs, cultures, x-rays, or anything else relevant to patient's condition

__ Copy of insurance card (front and back)

***Once the above information is received, we will call the patient to notify of the appointment date and time. A notification of the appointment will be faxed to your office. If your patient has questions, please refer to CarolinasHealthCare.org/ID-Consultants. Thank you your trusting us with your patient.**

ID Consultants & Infusion Care Specialists

4539 Hedgemore Drive, Charlotte, NC 28209 | Phone: 704-331-9669 | Fax: 704-688-0035