Carolinas HealthCare System

Center for Liver Disease Referral Form

Attn: New Referral Coordinator
Phone: (704) 355-6924 Fax: (704) 355-6998
Dr. Mark Russo and Greg Conner, PA

After completion of the form please fax to (704)355-6998 – along with legible copy of insurance card(s) and copies of patient's records.

***Patient Name: _____ Male Female Marital Status _____**

***Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____ Race: _____**

***Address: _____**
Street City State Zip

***Phone: home (_____) _____ cell (_____) _____ work (_____) _____**

Employment Status: _____Company Name: _____Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

***INS (**primary**): _____ Policy #: _____ Phone #:_____ INS Verified:__**

Subscriber (if different than patient**): _____ DOB _____/_____/_____ SSN: _____-_____-_____**

Insurance Authorization #: _____ (must be provided**) CA# (**Medicaid Only**): _____**

Retirement Date (if applicable**): _____ Spouse Retirement Date (**if applicable**):_____**

INS (secondary**): _____ Policy #: _____ Group #: _____**

***Referring Physician Name: _____Phone #: (_____) _____ Fax#: (_____) _____**

Address: _____
Street City State Zip

***Reason for Referral: _____ *Office contact person:_____**

ALLERGIES: _____

Primary Care Physician: _____Phone #: (_____) _____ Fax#: (_____) _____

==========

Appointment Date: _____ Time: _____ Provider Name: _____

CMC – Center for Liver Disease 1437 Scott Ave. Charlotte, NC 28203