



# SCOTT & WHITE

COLLEGE STATION

## Referral Form

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person's Fax #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ DR #: \_\_\_\_\_

Dept. Requested: \_\_\_\_\_

Please select one: \_\_\_\_\_ Consult Only \_\_\_\_\_ Evaluate and assume care

Preferred time of day: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

Preferred day of week: \_\_\_\_\_

Reason/DX: \_\_\_\_\_

\* Need: \_\_\_\_\_ H&P Dictation \_\_\_\_\_ Lab Results \_\_\_\_\_ X-ray \_\_\_\_\_ Results on all referrals

Appt. time requested: \_\_\_\_\_ 1 week \_\_\_\_\_ 1 month \_\_\_\_\_ 1<sup>st</sup> available

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Daytime phone #: \_\_\_\_\_

\_\_\_\_\_ Male \_\_\_\_\_ Female

\_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Social Security #: \_\_\_\_\_ MRN#: \_\_\_\_\_

(If child) Parent name: \_\_\_\_\_

Parent DOB: \_\_\_\_\_ Parent SSN: \_\_\_\_\_

Insurance Information: \_\_\_\_\_ Cardholder name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
(If different from patient)

Please fax this form and required records to (979) 691-3487. For questions, call (979) 691-3443.

Notes: Please fill out form and return with medical records for review. Please include an enlarged copy of the front and back of the patient's insurance card.

Thank you!