High Point Endocrinology - PA

REFERRAL FORM

DR. MONICA DOERR, MD

DATE: _____ REFERRING PROVIDER: _____

Patient's Name: _____ Date of Birth: _____

Patient Phone: (H): _____ (C): _____

Patient Address: _____

PLEASE FAX COPY OF PATIENT'S INSURANCE CARD AND DEMOGRAPHICS SHEET. OFFICE NOTES, RECENT LABS AND ANY PERTINENT IMAGING.PLEASE NOTE: OUR OFFICE DOES NOT ACCEPT MEDICAID

REASON FOR REFERRAL:

_____

_____

Does patient require a Translator? YES OR NO

High Point Endocrinology Staff will call the patient to schedule an appointment and fax appointment information to your office. Please provide your contact information below.

Phone#: _____ Fax#: _____ Contact: _____

Thank you for your Referral

1st attempt: Date: _____ Time: _____ Initials: _____

2nd attempt: Date: _____ Time: _____ Initials: _____

3rd attempt: Date: _____ Time: _____ Initials: _____

Appointment date & time: _____

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