

FAX REFERRAL

1414 MEDICAL CENTER DRIVE WILMINGTON, NORTH CAROLINA 28401
PHONE: (910) 763-7363 * FAX: (910) 251-8296

STAT REFERRAL? YES NO

* Please call (910) 763-7363 for **URGENT** referrals (same day appointments, DVTs)*

With this form please fax: Current Insurance Cards / Medical Records / Imaging Studies

PATIENT NAME _____	MALE	FEMALE
DOB _____ SSN _____		
ADDRESS _____		
HOME PHONE _____	CELL PHONE _____	
PRIMARY INSURANCE _____	SECONDARY INSURANCE _____	

CONSULT FOR _____	DIAGNOSIS/ICD10 CODE: _____				
REQUEST FIRST AVAILABLE PROVIDER: YES NO					
GENERAL/ABDOMINAL:		HARRIS	MEDLEY	VERSNICK	
BREAST:	BEBB				WEINBERG
ONCOLOGIC:	BEBB	HARRIS	MEDLEY	VERSNICK	WEINBERG
<i>(thyroid, skin, sarcoma, colon, esophageal, lymphoma, pancreatic, chemotherapy access)</i>					
BARIATRIC:		HARRIS			
VEIN/WOUND CARE:			MEDLEY	VERSNICK	

LAB ONLY APPOINTMENTS (Mark Tests Ordered)	
<input type="checkbox"/> L/E Venous (leg swelling, pain, cellulitis, varicose veins)	<input type="checkbox"/> Carotid (TIA, aphasia, amaurosis, stroke)
<input type="checkbox"/> U/E Venous (arm swelling, cellulitis)	<input type="checkbox"/> Aorta (NPO after midnight)
<input type="checkbox"/> L/E Arterial (claudication, arterial ulcer, rest pain)	<input type="checkbox"/> Renal Artery (24hr. clear liquid diet/NPO after Midnight day of)
<input type="checkbox"/> U/E Arterial (arm claudication, ulcer)	<input type="checkbox"/> Mesenteric (24 hr. clear liquid diet/NPO after Midnight day of)
<input type="checkbox"/> Health Screening Assessment (carotid, aorta, & arterial) \$110 for all three or \$40 each	

REFERRING MD _____ OFFICE PHONE _____ FAX _____

SENDER'S NAME _____ DATE FAXED _____