



PATIENT REFERRAL FORM

Please complete this form and fax to the office of your choice along with the patient's medical records including clinic/hospital notes, lab work and any other information pertinent to the referral. **Please send authorization number and a photo copy of the patient's current insurance card to complete the appointment process.** Baptist Medical Group will notify the patient and your office of the appointment date and time upon receipt of the requested information. We recommend you include a cover sheet to all faxed information.

Baptist Medical Group Practice Name: _____

Baptist Medical Group Physician Name: _____

Patient's name: _____ DOB: _____
SS#: ____ - ____ - ____ Home phone: (____) ____ - ____ Other phone: (____) ____ - ____
Address: _____ City/State/Zip: _____
Primary Insurance: _____ Policy #: _____ Auth#: _____
Secondary Insurance: _____ Policy #: _____ Auth#: _____

Date of Request: _____
Reason for referral: _____

Referring M.D. Name: _____
Referring M.D. Address: _____
Phone: _____ Fax: _____
Office contact name: _____

Appointment date: _____ **Appointment time:** _____

Patient contacted – Date: _____ **Time:** _____

Referring Physician contacted – Date: _____ **Time:** _____