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Referral Consult Request

** For *EMERGENT PROBLEMS*, requesting provider *MUST* call our office. All other requests are considered non-urgent. Please allow up to 10 days to process this request. **

Reason for Consult: _____ Date: _____

***Please include most recent office notes/labs/test results when faxing this referral.**
WE WILL NOT SCHEDULE UNTIL ALL HAVE BEEN RECEIVED. *

Patient Information

Name: _____ Date of Birth: _____

Address _____

Home Phone _____ Cell Phone _____ Gender: ☐ Male ☐ Female

Insurance / Billing Information

Primary Insurance: _____

ID #: _____

Secondary Insurance: _____

ID #: _____

****Referring Physician:** _____ ****NPI (Required):** _____

Office Phone Number: _____ Office Fax: _____

This appointment has been scheduled for

_____ at _____ with,
Date Time

☐ Bethany Hairston, M.D. ☐ Kala Wilson, CFNP ☐ Michelle Beasley, CFNP

The patient has been made aware of this appointment.

Thank you,

_____
Staff