REFERRAL REQUEST

PATIENT NAME: _____ _____ _____
First Last MI

GENDER: ○ MALE ○ FEMALE

DATE OF BIRTH: _____ PATIENT'S SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE PHONE: _____ OTHER PHONE: _____

PRIMARY INSURANCE: _____ ID #: _____

SECONDARY INSURANCE: _____ ID #: _____

PHYSICIAN PREFERANCE:

○ GLEN DOUGHERTY, MD, FACC ○ BASHIR LONE, MD, FACC, FACP

○ NORMA KHOURY, MD, FACC, FACP ○ NO PREFERENCE

APPOINTMENT TIME FRAME:

○ WITHIN 1 WEEK ○ NEXT AVAILABLE

REFERRING PHYSICIAN: _____ NPI #: _____

REFFERRING OFFICE: _____ OFFICE CONTACT: _____

PHONE: _____ FAX: _____

DIAGNOSIS / REASON FOR REFERRAL: _____

HOW DID YOU HEAR ABOUT US?: _____

PLEASE FAX OFFICE RECORDS, PATIENT DEMOGRAPHCS, AND INSURANCE CARDS WITH THIS FORM TO 803.255.2475.
THANK YOU!

2001 LAUREL STREET
COLUMBIA SC, 29204
MAIN PHONE: 803-365-VEIN (8346)
REFERRAL FAX: 803-255-2475