PALMETTO CARDIOLOGY ASSOCIATES

REFERRAL*FORM

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form back to the attention office scheduling.

Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call (803)252-6644

Date:	From:
No. of pages:	Title:
To: PCA	Phone:
Fax:	Fax:

PATIENT INFORMATION

Name of patient:

DOB: Interpreter needed: ❑ Yes ❑ No Language:

Home phone: ❑ Work or ❑ cell phone:

If child, name of parent:

Address:

City: Zip:

Insurance: Include patient's insurance card (both sides) and HMO authorization if required

CONSULTATION*REQUEST*INFORMATION

Diagnosis/ICD10

Name of PCA MD (if there is preference):

Reason for consultation:

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Signature: