



# Madison County Memorial Hospital

## REFERRAL FOR WELLNESS CLINICAL SERVICES

Date: \_\_\_\_\_

Number of pages (including this page) \_\_\_\_\_

Fax to: Madison County Memorial Hospital  
Outpatient Authorization Department

Fax #: 850-973-2937

Phone#: 850-253-1984

From: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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### Patient Information:

Patient's Name: \_\_\_\_\_  
(Last) (First)

Date of Birth \_\_\_\_\_ Phone Number \_\_\_\_\_ Cell \_\_\_\_\_

Referring Physician/Provider \_\_\_\_\_ Phone \_\_\_\_\_

Service(s) Requested: ☐ Wound clinic ☐ Infusion clinic

Indication(s) for Referral/Complaint:

\_\_\_\_\_  
\_\_\_\_\_

Attachments: (Please include the following documentation with your referral)

- ☐ Copy of Insurance cards
- ☐ H&P/ Last Office Visit Note
- ☐ Medication List
- ☐ CPT code/Procedure Code
- ☐ Yes, the patient is currently taking anticoagulant medications.
- ☐ Yes, the patient has a pacemaker.

MCMH will call the patient after insurance verification is completed to schedule an appointment.

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