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: _____

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.
