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
Local: 859-623-1932
Nashville: 859-813-1994

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.
