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:
____

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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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