Surgical Associates

OF NORTH ALABAMA, P.C.

PATIENT REFERRAL FORM

Referring Physician: _____ Date:_____

Office Contact:_____ Phone:_____ Fax:_____

Requested Physician: Walker Buckner Seale Figh Harney First Available
Emergent ? Yes No

Patient Name:_____

DOB:_____Male_____Female_____SS#_____

Phone:_____

Address:_____

Reason for Referral:_____

Primary Insurance: Policy number, Group number, Policy holder and DOB:

_____

Secondary Insurance: Policy number, Group number, Policy holder and DOB:

_____

Tertiary Insurance: Policy number, Group number, Policy holder and DOB:

_____

Any testing performed? Yes No **Please fax pertinent office visit before appointment**

If Yes, what test(s):_____

Date:_____ Facility:_____

Appointment Scheduled by: Date: Time: Pt Notified: Yes No

*** IN ORDER TO AVOID APPOINTMENT DELAYS PLEASE FAX ALL RECORDS/RESULTS WITH THIS FORM***

P. O. Box 1029 1405 7th Street SW Decatur, AL 35602
Phone 256-355-6414 Fax 256-355-6646