

PHYSICIAN CONSULTATIONS

PLEASE COMPLETE THE FOLLOWING FORM

DATE: _____

REFERRING PHYSICIAN: _____

REASON FOR REFERRAL: _____

Please indicate to which physician you are referring:

- First Available Physician
- Larry K. Broadwell, M.D.
- Nicole M. Cotter, M.D.
- Aaron W. Broadwell, M.D.

PATIENT NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

PRIMARY INS: _____ SECONDARY INS: _____

PLEASE FAX THIS FORM WITH THE FOLLOWING INFORMATION:

1. Patient demographics
2. Copy of all current insurance cards (front and back).
3. Progress notes for the past 12 months only unless physician/midlevel practitioner deems more is warranted.
4. Lab reports.
5. X-ray or MRI reports.

****FAILURE TO COMPLETE THIS FORM OR TO SEND THE REQUIRED INFORMATION MAY RESULT IN YOUR PATIENT'S APPOINTMENT BEING DELAYED OR CANCELLED.**

If the patient is being referred for physician consultation for osteopenia or osteoporosis, please mail a print out of all of their bone density scans. Please do not copy or fax these items. Also, indicate if the patient will require a bone density the day of their new patient appointment.

If your patient is a "NO SHOW" or cancels less than 24 hours prior to the appointment, they may not be given another appointment.

THANK YOU FOR YOUR REFERRAL!!

Scheduling information for In-Office use only:

Appt date/time: _____ Date sent/faxed: _____ Packet mailed: _____ Rec'd: _____

Complete/Incomplete: _____ INITIALS: _____