

2223 Hemby Ln Phone 252-413-0036

Greenville, NC 27834 Fax 252-413-0038

*Referral Request*

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| **Referring Provider Information** |
| Name of individual initiating referral: |
| Referring Provider: |
| Referring Facility: |
| Phone (*Best phone # to reach you*): Fax: |
| Provider Requested *(Please circle one)*: Habal Cupp First Available |

**Patient Information (*Please provide copy of patient demographics/face sheet*):**

|  |  |
| --- | --- |
| Referral Date: |  |
| Patient Name: |  |
| Date of Birth: |  |
| SSN: |  |
| Address: |  |
| Home Phone: Work Phone: Cell Phone: | |
| Insurance: |  |
| Authorization: |  |
| Medicaid CA Auth: | NPI # # of visits: Exp: Rep: |

**Reason for Referral**

|  |  |
| --- | --- |
| Palpable: Y or N | |
| Mammogram: | Date: Birads/Category: |
| Ultrasound: | Date: Birads/Category: |
| MRI: | Date: |
| Miscellaneous Test: | Date: |
| **Documentation Required (*Please fax with this form*):**   * Mammogram report * Recent/relevant clinical notes, test results and h&p * Medication list | |

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| **CBOS ONLY** |
| Appointment Date: Time: |
| MRN: |