Winder Internal Medicine and Geriatrics Center P.C.

20 Satellite Dr. Ste 100, Winder, GA 30680
Phone (770) 586-0310, Fax (770) 586-0312

Referral Form

Patient Information

Name _____ Gender □ Male □ Female
Last First Middle

Date of Birth _____ / _____ / _____ Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Reason for Referral: _____

_____

Primary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Policy Holder _____ Relation to Patient _____ Date of Birth _____
Last First MI

Social Security #_____ Phone _____

Secondary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Please fax us or send with the patient any recent PFTs, chest imaging (both report and digital film if available), echo results and any other work up that you expect to be useful.

A response letter will be faxed to the referring physician within 1 business day of the initial consult and all subsequent visits.

[ ] Please check this box if the referring physician or primary care would like to be called after we see the patient to discuss the case on phone

Please Fax complete form to (770) 586-0312