



Today's Date:

CLINIC DIVISION OF UNC DEPARTMENT OF SURGERY

To refer a patient to the following division, please fax this form to the number below:

Plastic & Reconstructive Surgery Fax: 919-843-8251 / Phone: 919-843-9091

Is this a joint case (to be coordinated with another surgical specialty)? Yes No If yes, which specialty:

REASON FOR REFERRAL

Diagnosis/ ICD-9 Codes:

Name of Requested Clinician: (if applicable) Onset Date of Signs and Symptoms: / /

Reason for Referral: Consultation and Recommendations, then return to referring provider for care Transfer of Care for this problem 2nd Opinion

Clinical Documentation: (Required to expedite scheduling)

For Internal Referral: In webCIS, Location in webCIS: For External Referral, patient records and radiological reports have been: Faxed Mailed Date Sent:

REFERRAL SOURCE INFORMATION

Referring Provider Name: Provider #: (For Internal Providers) Pager #: (For Internal Providers)

Address: Phone #:

Fax #:

PATIENT INFORMATION

UNC Medical Record#:

Last Name: First Name: Middle:

Parent/Guardian Name, if patient is under 18 years:

Interpreter Needed? Yes No If yes, language: Spanish Other

\*For all patients new to UNC, the following MUST be completed. \*For patients already in the UNC system, please update any changes below. If no changes, please go to Insurance section.

Sex: M F DOB: / / SSN#:

Street Address: City: State: Zip Code:

Daytime Phone #: Alternate Phone#:

INSURANCE INFORMATION

Insurance Name: (note if no insurance coverage) Authorization Required: Yes No Authorization #: # of visits: Effective Dates:

CONFIRMATION OF SCHEDULED APPOINTMENT

(Once appointment has been scheduled by staff, the following information will be completed and faxed back)

Appt Date: Appt Time: Provider Name: