

# UNC GENERAL SURGERY NEW PATIENT REFERRAL FORM

(PLEASE PRINT IN BLACK INK) Please complete all sections and fax back to the General Surgery Department, thank you.

Fax# 919-966-0369

## Patient Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

UNC MR#: \_\_\_\_\_ Day Phone#: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Alternate#: \_\_\_\_\_ (Contact person if available: \_\_\_\_\_)

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ \*CONTACT PRECAUTIONS: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Insurance: \_\_\_\_\_ Authorization#: \_\_\_\_\_

Visits: \_\_\_\_\_ Dates: \_\_\_\_\_

Translator needed?: Y \_\_\_ N \_\_\_ Language: \_\_\_\_\_

REASON FOR REFERRAL (diagnosis, relevant history, signs, and symptoms): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Called pt: \_\_\_\_\_ left message \_\_\_\_\_ no answer

Ref Physician: \_\_\_\_\_ UNC Referral Code: \_\_\_\_\_ Telephone# \_\_\_\_\_

Address: \_\_\_\_\_

**Please also include the most recent laboratory values, radiological studies, and clinic notes pertaining to this referral.**

**Appointment will not be scheduled if notes are not received!**

**We thank you for allowing us to participate in the care of your patient.**



**FOR DEPT. OF SURGERY USE ONLY:**

TUES: \_\_\_\_\_ HER454

APPT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ SRH/894 / CLINIC CODE: \_\_\_\_\_ 900001GEN THUR: \_\_\_\_\_ 700922

Sched by: JTD LDB PSP / phone 6-4389 fax 6-0369

CBA \_\_\_\_\_ TIME \_\_\_\_\_ DATE \_\_\_\_\_