

## **CLINIC REFERRAL FORM**

HEALTH CARE		Today's Date:	······································			
CLINIC DIVISION OF UNC DEPARTMENT OF SURGERY						
To refer a patient to the following division, please fa				JUNG		
UNC DIV	TSTON OI	F DI ASTIC	SIIRE	FRY		
UNC DIVISION OF PLASTIC SURGERY Fax: 919-957-6906 / Phone: 919-843-3734						
Is this a joint case (to be coordinated with another surgica				, which specia	lty:	
REASON FOR REFERRAL  Diagnosis/ ICD-9 Codes:						
Diagnosis/ 1cD-5 codes.						
Name of Requested Clinician: (if applicable)				Onset D Signs a	Date of nd Sympto	oms: / /
Reason for Referral: Consultation and Recommend then return to referring provide		☐ Transfer of Care for this problem ☐ 2 <sup>nd</sup> Opinion				
Clinical Documentation: <i>(Required to expedite scheduling</i> For Internal Referral: $\square$ In EPIC, Location in EPIC		-				
For External Referral, patient records and radiologi	ical reports hav	ve been:	Faxed	Date Se	nt:	
	RRAL SOUF	RCE INFORM				
Referring Provider Name:		Provider #: (F	For Interna	val Providers)	Pager #	: (For Internal Providers)
Address:		<u> </u>		Phone #:		
1			-	Fax #:		
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	PATIENT I	NFORMATIO	)N			
UNC Medical Record#:				·····		
Last Name:	First Name:					Middle:
Parent/Guardian Name, if patient is under 18 years:						<u>i</u>
Interpreter Needed?						
*For all patients new to UNC, the following MUST be completed with a copy of the demographic information.  *For patients already in the UNC system, please update any changes below. If no changes, please go to Insurance section.						
Sex: M F DO	OB: /	1	SSN#:			
Street Address:	City	/:	<u> </u>	Sta	ate:	Zip Code:
Daytime Phone #:	Alte	ernate Phone#:				
Ir	NSURANCE	INFORMATI	ION			
(Please attach	h a copy of	the insuran	ce info			
Insurance Name: (note if no insurance coverage)	Aut	thorization Requ	ıired:	☐ Yes	☐ No	
	Aut	thorization #:			·	# of visits:
	Eff	ective Dates:			-	
CONFIRMATION OF SCHEDULED APPOINTMENT  (Once appointment has been scheduled by staff, the following information will be completed and faxed back)						
Appt Date: Appt	Appt Time: Provider Name:					