PATIENT REFERRAL FORM

Date: _____ UAB MR#: _____

Referring MD: _____ City/State: _____

Phone: _____ Fax: _____

Office Contact: _____

Email address for appointment confirmation: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

SSN (Required): _____ Phone: _____

Address: _____

City, State, Zip: _____

Insurance: _____ Contract #: _____

Group #: _____ Name on Insurance: _____

2nd Insurance: _____ Contract #: _____

Group #: _____ Name on Insurance: _____

Diagnosis/Reason for Referral (Required): _____

Specialty Requested: _____ UAB MD Requested: _____

Notes: _____

_____

_____

Please complete the form in its entirety and return via fax with related medical records to 205.996.9107 or email to physicianservices@uabmc.edu. To speak with Physician Services, please call 205.934.6890. A scheduler will contact your office with the appropriate information. Also note: we do not contact patients regarding appointment information.

Thank you for choosing UAB Medicine!

UAB MEDICINE

The University of Alabama at Birmingham