

1221 South Broadway  
Lexington, KY 40504  
Phone: 859.258.4DOC (4362)  
Fax: 859.258.6118  
E-mail: jewil@lexclin.com



# Referral Form

Please fax this form and the required information to **859.258.6118**.

Contact Person: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Person's Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ DR. #: \_\_\_\_\_

Department Requested: \_\_\_\_\_ DX Numerical Code: \_\_\_\_\_

Reason/DX: \_\_\_\_\_

Select one:  Consult Only  Evaluate & Test  Evaluate, Test & Treat

Information included:  H & P  Lab results  X-ray  Results of all referrals

Preferred time of day:  AM  PM Preferred Day of week: \_\_\_\_\_

Appointment time requested:  1 week  1 month  1st Available

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ MRN#: \_\_\_\_\_  Male  Female

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

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home phone #: \_\_\_\_\_ Daytime phone #: \_\_\_\_\_

(If child) Parent name: \_\_\_\_\_

Parent DOB: \_\_\_\_\_ Parent SSN: \_\_\_\_\_

Insurance: \_\_\_\_\_ (copy of insurance card preferred)

Cardholder name: \_\_\_\_\_ DOB: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_