EPIC HEALTH
INFECTIOUS DISEASES

NEW PATIENT APPOINTMENT REFERRAL FORM

We cannot make an appointment unless all the information below is complete

Please circle ONE: First available Dr. Jack Austin Dr. Brian Catto

FAX REQUEST FOR INFORMATION

To:_____ Fax# 706-434-1595 Date: _____

From: _____ Phone:_____Fax# _____

Please send patient demographics, copy of insurance card (front and back), recent labs, x-rays and any recent office notes pertaining to referral. (HMO/POS, Medicaid, Tricare MUST have referral faxed with this form).

Patient Name: _____

SSN:_____DOB:_____

Address:_____

City:_____State:_____Zip:_____

Home#_____work#_____cell#_____

Referring MD:_____ph#_____fax#_____

Contact person for referring MD:_____

Primary Care Physician:_____

Reason for referral:_____ Type of Infection:_____

Which hospital were you in?_____

Have you had any recent lab procedures?[ ]Y [ ]N If so, where?_____when?_____

Date and time of appointment:_____scheduled by:_____

Patient Contacted:_____