New Patient Referral Form

CoxHealth Diabetes and Endocrinology
121 Cahill Road, Suite 201
Branson, MO 65616
Phone: 417-348-8990 Fax: 417-348-8090

REFERRING CLINIC INFORMATION | Date:
Referring Clinic Name: | Clinic Contact Name:
Referring Provider Name:
Phone: | Fax:

PATIENT INFORMATION
Patient Name: | Patient Date of Birth:
Home Address:
Home Phone: | Cell Phone:
Work Phone: | ☐ Male ☐ Female ☐ Other (Specify):
Primary Language: | Interpreter Needed: ☐ Yes ☐ No
Contact Name: | Contact Relationship:
1st Insurance: | Policy: | Group:
2nd Insurance: | Policy: | Group:
Is this a Work Comp related injury? ☐ Yes ☐ No
If yes, please complete and fax referral to Work Complete at 417-269-2668
Employer Name/Contact information:

REFERRAL INFORMATION
☐ First Available Physician | Specific Physician requested (if applicable):
Appointment Urgency: ☐ Urgent ☐ Next Available ☐ 1-2 Weeks ☐ Neck Mass
Select one of the following: ☐ Consult on this condition and treat if needed ☐ Assume care of this condition
Diagnosis/Complaint:

Chronic? ☐ Yes ☐ No | Date of Injury/Symptoms:
Specify site/side affected:

This form must be completed and faxed with the following:

1) All office notes pertaining to the diagnosis/reason for referral
2) Any labs and diagnostic testing/imaging pertaining to the diagnosis/reason for referral
3) Patient medication list
4) Copy of patient's insurance card(s) including front and back and valid photo ID

Fax this completed form to: 417-348-8090

The patient will be scheduled as soon as possible and we will notify you of the appointment date and time.
Appointments will not be scheduled until all records are received.

OFFICE USE ONLY
Appointment Information:
Provider: | Date: | Time:
Patient notified: ☐ Yes ☐ No | Staff Initials: