New Patient Referral Form

CoxHealth Skin Care Clinic
1925 W Chesterfield Blvd.
Springfield, MO 65807
Phone: 417-269-9060 Fax: 417-269-9061

REFERRING CLINIC INFORMATION

Referring Clinic Name: Date:
Referring Provider Name: Clinic Contact 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):

If this referral is URGENT check here ☐

Diagnosis/Complaint:

Chronic? ☐Yes ☐No Date of Injury/Symptoms:

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: 417-269-9061

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: