Referral Form

Please complete, **PRINT**, and fax form with notes to Referrals at 910-484-1673. If you have any questions or if this an urgent request, please call 910-484-2284.

Referring Physician Information

Referring Physician: _____ Date: _____
Practice/Group Name: _____
Address: _____
City/State: _____ Zip Code: _____
Office Phone: _____ Office Fax: _____
Referral Coordinator: _____ Phone Ext: _____

Patient Information

Patient Name: _____ Sex: _____
Social Security #: _____ Date of Birth: _____
Address: _____
City/State: _____ Zip Code: _____
Home Phone: _____ Patient E-mail: _____
Work Phone: _____ Cell Phone: _____
Parent or Guardian Name if Minor: _____

Insurance Information

Attach copy of insurance cards (front & back) with complete insurance information OR complete the following:

Insurance Plan: _____ Ins. Co. Phone #: _____
Ins. Co. Address (only if commercial plan): _____ State: _____ Zip Code: _____
Subscriber ID: _____ Member ID (if different from Subscriber ID): _____
Subscriber Name: _____ Subscriber DOB: _____ Group #: _____
Subscriber Relationship to Patient: _____ Guarantor (If different from Subscriber): _____
Guarantor DOB: _____ Guarantor Phone Number: _____
Is this a plan with referral restrictions? ☐ YES ☐ NO Referral/Authorization #: _____
Is this patient with Medicaid? ☐ NC Medicaid ☐ Non-NC Medicaid ☐ NO Carolina Access # _____
Is Workers' Compensation or litigation involved? ☐ YES ☐ NO

Appointment Request If emergent, please call 910-484-2284.

☐ Urgent (<3 days) ☐ 4-14 days ☐ Routine (next available)
Preferred Day/Time for Appointment: _____
Preferred Location: _____
Reason for Appointment and/or Primary Complaint: _____
Specialty Requested: _____
Specific Physician Request (if known): _____
Recent studies (lab, x-ray, etc.) and dates performed: _____
(Please have patient bring radiology scans on CD to their appointment.)

For Office Use Only

Appointment Date and Time: _____
Department/Physician: _____
Location: _____
Patient notified? ☐ YES ☐ NO Spoke with patient: _____ Left message: _____ Via letter: _____
Referring office notified ? ☐ YES ☐ NO Left message: _____ Fax Sent: _____
Notes: _____

Thank you for referring your patient to Cape Fear Eye Associates.