USA HEALTH

USA PHYSICIANS GROUP REFERRAL FORM

Please complete this form in its entirety and fax to (251) 405-9900 with all pertinent records. Thank you!

REFERRING PROVIDER INFORMATION

OFFICE CONTACT'S NAME	OFFICE CONTACT'S PHONE #
OFFICE CONTACT'S EMAIL ADDRESS	OFFICE CONTACT'S FAX #
REFERRING PROVIDER'S NAME	
CLINIC OR PRACTICE NAME	TODAY'S DATE

PATIENT INFORMATION

NAME			
CONTACT PHONE #		EMAIL ADDRESS	
DATE OF BIRTH	AGE	GENDER	PATIENT'S INSURANCE NAME(S) - PLEASE FAX INSURANCE CARD COPIES

REFERRAL INFORMATION

REFERRAL PRIORITY (CIRCLE ONE)

STAT (WITHIN 24 HOURS) **URGENT (WITHIN 2 TO 5 DAYS)** **STANDARD/ROUTINE (WITHIN 30 DAYS)**

ARE MEDICAL RECORDS AND ANY APPLICABLE TEST/SCAN RESULTS ATTACHED? (CIRCLE ONE)

YES **NO**

TO WHICH USA CLINIC, DEPARTMENT, DIVISION, OR PROVIDER ARE YOU REFERRING THIS PATIENT?

WHAT IS THE REASON FOR THIS REFERRAL?