



USA HEALTH

University of South Alabama Health

REFERRAL FORM

Thank you for your referral! USA Health is honored to care for the needs of your patient. Remember there are **3 easy ways** to refer a patient to USA Health. Call us at 833-872-4584, online at: usahealthsystem.com/refer or by utilizing this fax referral form.

Please complete this form in its entirety and fax, along with all related medical records, to (251) 405-9900.

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			SOCIAL SECURITY NUMBER		
MOTHER'S NAME (IF PATIENT IS UNDER 18)		MOTHER'S DATE OF BIRTH	FATHER'S NAME (IF PATIENT IS UNDER 18)		FATHER'S DATE OF BIRTH
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)					
*PLEASE NOTE THAT WITHOUT RECORDS, THE APPOINTMENT MAY HAVE TO BE RESCHEDULED.				YES	NO
TO WHICH USA HEALTH DEPARTMENT ARE YOU REFERRING THIS PATIENT? *Please note if a specific physician is requested.					
WHAT CLINICAL QUESTION DO YOU WANT THE RECEIVING USA HEALTH MEDICAL PROVIDER TO ANSWER?					