



## Patient Referral Request

### Referral Coordinators:

Thank you for trusting us with the care of your patients! Complete Sections 1 and 2 below. Then fax this form, along with the patient's medical records and authorization information, to 704-752-7576. We will schedule the appointment and fax the information back to you for your records.

### 1. Referring Provider Information:

Referring Practice: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 2. Patient Information:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Parent's Name (first and last) if patient is a child: \_\_\_\_\_

Preferred Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Diagnosis/Complaint: \_\_\_\_\_

Preferred Office:  Monroe  Charlotte (Arboretum)  Indian Land  First Available

Preferred Physician:  First Available  Daniel Gerry, MD  Matthew Gillihan, MD

William McClelland, MD  Karen Greene, PA-C  Natalie Macknet, FNP-C

Will an interpreter be needed? Yes / No Language: \_\_\_\_\_

***Please have your patients visit our website at [www.CornerStoneENT.com](http://www.CornerStoneENT.com) to request an invitation to our patient portal.***

\*\*\*\*\*Section below for use by CornerStone Ear, Nose & Throat\*\*\*\*\*

Appointment Scheduled: Patient ID: \_\_\_\_\_ ID#: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Audiology: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Charlotte (Arboretum)  Monroe  Indian Land