THE *Women's* CARE CENTER

REFERRAL FORM

☐ 10235 Hickorywood Hill Ave., Huntersville, NC 28078
☐ 508 Eastway Drive, Charlotte, NC 28205

FAX # 1888.334.4261

Name: ________________________________ Date: ______________

DOB: ______________ Social Security:____-___-________

Valid Contact Numbers: Home: (____) ______________ Cell (___)______________

Work: (____)______________ Next of Kin: (___)__________

Referral Indication: ____

Additional comments ____

Medical records sent: Yes ☐ No ☐

Appointment Date: __________________ Time: ______________

Has patient been notified regarding indication for referral? : Yes ☐ No ☐

Comments____

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INFORMATION TO REFERRING PROVIDER AND PATIENT

1. Please plan to be present 20 minutes before the appointment time in order to fill-out paperwork
2. Co-pay required for the visit, as indicated by insurance.
3. If patient is less than 18 years old and non-pregnant, she must be accompanied by a parent or legal guardian who will sign the consent.
4. Appointment cancelled without notice may be billed.