Need Assistance?
Physician Helpline: 812-336-6008

Referral Request Form

(Items with ** are required for processing)

Phone: 812-336-6008 | Fax: 812-339-6947

Patient Information

Reason for Referral

If Medical Records Cover Sheet is included, Patient information can be left blank	Priority: Routine ☐ **Medically Urgent** ☐
Name *(First, Middle, Last)*** Sex: ☐ Male ☐Female	**If Medically Urgent**, please describe:
Date of Birth**	Diagnosis/ICD 10**
Phone # ** Secondary Contact #	Clinic / Specialty Requested**
Address**	Physician Requested Location Requested
City** Zip Code** State	If Requested Physician is Unavailable, Can Patient be seen by another provider? ☐ Yes ☐ No ☐ Contact Referring Provider
Interpreter Needed? Yes ☐ No ☐ Preferred Language:	☐ Consultation ☐ 2nd Opinion ☐ Procedure ☐ Other

Referring Provider Information

Referring Provider Name**			PCP Name
Practice Name**			
Office Address**			City**
State**	ZIP Code**		NPI Number
Phone**	Fax**	Provider Specialty	

Documentation Requested

☐ Relevant Clinical Notes **(History & Physical, Imaging and Lab results)**

☐ Copy of Insurance Card ☐ Insurance Authorization Information (If required)