



**EMPLOYEE & DEPENDENT SPECIALTY CLINIC REFERRAL FORM**

**PATIENT INFORMATION**

NAME		DOB	SOCIAL SECURITY NUMBER
ADDRESS		PHONE NUMBER	

**INSURANCE INFORMATION- \*PLEASE OBTAIN AUTHORIZATION PRIOR TO SUBMISSION IF REQUIRED.**

PRIMARY INSURANCE		POLICY NUMBER
AUTHORIZATION REQUIRED?		AUTHORIZATION NUMBER
YES	NO	

**REFERRAL INFORMATION**

REFERRAL TO (CIRCLE ONE):			
ASTHMA/ALLERGY	FAMILY PLANNING	NEUROSURGERY	PODIATRY
CARDIAC	GENERAL SURGERY	OB/GYN	PRIMARY CARE
COUMADIN	GERIATRIC	ORAL SURGERY	PULMONARY
DERMATOLOGY	GI	OPHTHALMOLOGY	RENAL
DIABETES	INFECTIOUS DISEASE	ORTHOPEDIC	UROLOGY
ENDOCRINE	MEMORY CLINIC	PLASTIC SURGERY	
ENT	NEUROLOGY	OTHER _____	

**REASON FOR CONSULT:**

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**NPI#**

**TaxID#**

REFERRING OFFICE/FACILITY NAME	REFERRING PHYSICIAN NAME & NPI
OFFICE TELEPHONE NUMBER	OFFICE FAX NUMBER

**GRADY HEALTH SYSTEM USE ONLY**

Appointment Date	Appointment Time

**EMPLOYEES & DEPENDENTS ONLY FAX FORM TO: (404)616-5700  
Call (404)-616-2500 to schedule an appointment**