DIABETES & ENDOCRINE WELLNESS CENTER, LLC

1 Hospital Drive SW, Suite 300
Huntsville, AL 35801
Phone: 256-881-2700 Fax: 256-429-9109

ATTENTION: Patient WILL NOT be scheduled without ALL the requested forms. After we receive the referral information in its entirety, we will contact the patient directly to schedule an appointment. Please allow 5-7 days for this process. Please ask your patients to wait for a call from our office. We thank you in advance for your help.

* **COMPLETED REFERRAL FORM**
* **HISTORY AND PHYSICAL**
* **PHYSICIAN PROGESS NOTES**
* **CURRENT MEDICATION LIST**
* **COPY OF INSURANCE CARD AND DRIVER'S LICENSE** (OR LEGIBLE PRINTOUT WITH THE INFORMATION)
* **CURRENT LABS** (A1C FOR DIABETICS; TSH, FT4 FOR PATIENTS WITH HYPO or HYPERTHYROIDISM)
* **TRICARE REFERRAL**
* **MEDICAID PATIENT FIRST REFERRAL** (PRINTOUT FROM MEDICAID WEBSITE VERIFYING THAT REFERRAL IS BEING SENT FROM THE CORRECT FACILITY AND GROUP PRACTICE NPI NUMBER)

Please use this form as your cover sheet

PATIENT INFORMATION	REFERRING PHYSICIAN INFORMATION
Patient Name: ______________________	Practice Name: ______________________
❑ Male ❑ Female Age: ________ DOB: ________________	Physician Name: ______________________
+ Home Phone#: ______________________	Office Contact: ______________________
Cell Phone#: ______________________	Phone#: ______________________
Address: ______________________	Street Address: ______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Insurance Carrier (#1): ______________________	Fax #: ______________________
Group#: ________________ Policy#: ______________________	NPI #: ______________________
Insurance Carrier (#2): ______________________	Reason for Consultation: ______________________
Group#: ________________ Policy#: ______________________	______________________
Race: ____________ Primary Language Spoken: _____________	

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Referring Provider's Signature: ______________________________ **Date:** ________________

REVISED 12/2016