

OUTSIDE REFERRAL FORM

SEND ALL INFORMATION TO THE P.E.T. FACILITY

FAX: (919) 684-7130

Wanda Cooper, Radiology Patient Representative

Telephone: (919) 684-4908 Fax: (919) 684-0839

Sharron Lewis, Duke North Radiology Clinical Supervisor

Telephone: (919) 684-7306 Fax: (919) 684-7142

If a legible copy of ALL insurance documentation accompanies this form,
the 2nd page does not need to be completed.

MRN _____ Social Security # _____

Name _____ Maiden Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

City if Birth _____ State of Birth _____

Home Phone # _____ Work phone # _____

Employer _____

Parent's First Name _____

Emergency Contact Person _____

Relationship _____ Phone # _____

Procedure _____

Diagnosis _____

Date of Procedure _____ Time _____ Authorization Code _____

Known Drug Allergies _____

Referring Physician _____

Address _____

Telephone # _____ Fax # _____

Scheduler's Name _____ Phone # _____

IF THE PATIENT IS A CHILD, THE FOLLOWING PARENT OR GUARDIAN INFORMATION IS REQUIRED

Parent's Name _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Employer _____ Work Phone # _____

Insurance Information

Company _____
Address _____ Phone # _____
Certificate # (usually SS#) _____ Group _____
Subscriber's Name _____ Relation to Patient _____
Subscriber's Employer _____ Subscriber's Date of Birth _____
Primary Care Physician _____ Phone # _____

Does the insurance company require a Refferal to a specialist or for any procedures associated with a visit to Duke? _____

Authorization Code _____

Medicare Information

Name as it appears on your Medicare card _____
Claim # _____
Effective Date (Medicare part B at bottom of the card) _____
Are you retired? No Yes When _____
Is your Spouse retired No Yes When _____
Primary Care Physician _____ Phone # _____

Medicaid Information

Name as it appears on your Medicaid card _____
Claim # _____
What state issued your Medicaid _____
Do your have Carolina Access? No Yes
Do you need a referral to be seen at Duke No Yes
Primary Care Physician _____ Phone # _____

Champus Information

Name as it appears on your military ID card _____
Military sponsor's name _____
Relationship to patient _____
Sponsor's Social Security # _____
Branch of Service _____ DEERS enrolled? No Yes
Duty Status _____ Pay Grade _____
If active Duty Station (Name and Address) _____
