Cape Fear Arthritis Care

1003 Olde Waterford Way, Suite 1B / Leland, NC 28451 / 910-679-3212 / www.cfac.co

Patient Referral Form

Fax To: 877-718-8984

Please include all of the following:

- This form (completed)
- Recent office note with reason for referral
- Current imaging/labs if applicable
- Copies of Patient Demographics & Insurance Cards

Questions? Call 910-679-3212

Referred To:

☐ David H. Snow, MD

☐ Lisa M. Schaefer, MPT

Today's Date: _____

Patient Name: _____

DOB: _____ SS# _____

Patients preferred phone # _____

Male ☐ Female ☐ / Child? Yes ☐ No ☐

Diagnosis/reason for referral: _____

_____

_____

Primary Insurance: _____

Referring Provider: _____

Practice Name: _____

Phone: _____

NPI: _____

Required for Carolina Access patients ONLY:

PCP: _____

PCP Phone: _____

PCP NPI: _____

Secondary Insurance: _____

If Tricare Prime, Authorization # _____

— — — — — — — For Cape Fear Arthritis Care Use — — — — — — —

Date Pt Contacted	Initials	Comments

Appointment Scheduled For: ___/___/___ **Time:** _____ **AM / PM** **By:** _____