VISTA WOMEN'S HEALTHCARE
A Lexington Medical Center Physician Practice

700 Gervais Street, Suite 300, Columbia, SC 29201
Ph: (803) 254-3230 • **Fx:** (803) 540-1180
VistaWomens.com

REFERRAL FORM

Patient Name: ______________________ Today's Date: __________

Date of Birth: __________ Social Security No: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone: (Home) __________ (Work) __________ (Cell) __________

INSURANCE INFORMATION

Primary Insurance: ______________________

Insurance Authorization If Required: ______________________

Insurance Address: ______________________

ID#: __________ Group#: __________

Policy Holder Name: ______________________ DOB: __________

REFERRING PROVIDER INFORMATION

Referring Physician/Provider: ______________________ NPI: __________

Contact Name: ______________________

Phone: __________ Return Fax: __________

Reason for Referral/Diagnosis: ______________________

PHYSICIAN REQUESTED

☐ John H. Moore, MD ☐ Kathryn L. Moore, MD ☐ Abigail Scheuer Smith, MD ☐ Beverly Summer, WHNP-BC ☐ First Available

APPOINTMENT REQUESTED

Day and/or time requested: ______________________ ☐ ASAP ☐ Next Available

REASON FOR REFERRAL

☐ New Patient (assume GYN Care)
☐ Consult & Recommendations
☐ Colposcopy (current pap results required)
☐ Urodynamics Only
☐ Ultrasound Only
☐ DEXA Only
☐ Screening Mammogram
☐ ______________________
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GENERAL INFORMATION

Please have patient bring insurance card to appointment. If insurance authorization is required, please obtain this prior to finalizing appointment. Please fill out form completely and **attach a copy of referring provider's recent office note or any pertinent labs or test results.** We will schedule your patient appointment and fax this form back to you with appointment date and time as well as request for any additional required information. If immediate assistance is required regarding patient care, please call (803) 254-3230.

Thank you for your referral! • Fax to: (803) 540-1180

APPOINTMENT SCHEDULED

Appointment Date: __________ Time: __________ Provider: ______________________

Location: ______________________ Patient notified of appointment: ______________________