Patient Referral Request

Referral Coordinators:

Thank you for trusting us with the care of your patients! Complete Sections 1 and 2 below. Then fax this form, along with the patient's medical records and authorization information, to 704-752-7576. We will schedule the appointment and fax the information back to you for your records.

1. Referring Provider Information:

Referring Practice: ______________________ Date: ______________

Referring Physician: ______________________________________

Phone: ________________ Fax: ________________

2. Patient Information:

Patient's Name: ______________________ Date of Birth: __________

Insurance: ______________________ Insurance ID#: ______________

Parent's Name (first and last) if patient is a child: ______________________

Preferred Phone Numbers: Home: ______________ Cell: ______________

Diagnosis/Complaint: ______________________________________

Preferred Office: ___Monroe ___Charlotte (Arboretum) ___Indian Land ___First Available

Preferred Physician: ___First Available ___William McClelland, MD ___Jeffrey Brink, MD ___Daniel Gerry, MD ___Karen Greene, PA

Will an interpreter be needed? Yes / No Language: ______________

Please have your patients visit our website at www.CornerStoneENT.com to request an invitation to our patient portal.

*****************Section below for use by CornerStone Ear, Nose & Throat*****************

Appointment Scheduled: Patient ID:______________ ID#: ______________

Physician: ______________ Date: ______________ Time:__________

Audiology: ______________ Date: ______________ Time:__________

Charlotte (Arboretum)___ Monroe ___ Indian Land ___

tel | 704.752.7575
fax | 704.752.7576
web | www.CornerStoneENT.com

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8035 Providence Road, #320
Charlotte, NC 28277

Monroe
1107 Reynolds Street
Monroe, NC 28112

Indian Land
7666 Charlotte Hwy., #220
Indian Land, SC 29707