THE CAPE FEAR FOOT CENTER

DR. CHRISTOPHER C. YOUNG, D.P.M.
Physician & Surgeon of the Foot

REFERRAL FORM

PHONE: (910)-763-9334 FAX: (910)-763-9339

Date Referred: ________________
Referring Physician: ______________________ Phone: ___________________ Fax: _______________

PATIENT INFORMATION:

Patient Name: ________________________________ Date of Birth: ______________ Gender: M / F
Patients name (If the patient is a minor): ______________________________
Home Phone: __________________ Cell: ____________________ Work: ______________________
Patient's Address: ____
City: _________________________________ Zip: ______________________

Authorization: ___ Not Required ___ Requested/Pending ___ Requested/Obtained Auth# ______________

Primary Medical Insurance: ____________________________ Subscriber ID# ____________________
Secondary Medical Insurance: __________________________ Subscriber ID# ____________________

Reason for Referral:

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Please send a list of patient medications, medical history (surgeries included), and a list of documented allergies.

__ We will contact patient to schedule __ Please have patient call to schedule __ Please call to schedule

Appointment is scheduled with: __________________________ on __________________ at ___________ arrival time.

Date faxed back to referring physician: ________________