OUTPATIENT CASH CLINIC REFERRAL FORM

Fax to 318-333-3075

Please complete all sections of this form, preferably by typing. Your patient will receive a phone call with the details of their scheduled appointment. For all inquiries please telephone 318-303-3077. Please call Epiphany Health with an urgent referral.

Patient details

Last Name:_____ First names:_____

Date of birth:_____ Sex: Male ☐ Female ☐

If under 18, provide Guardian's Name: _____

Address:_____

_____

Preferred contact number: Mobile*_____(2) Other _____

Insurance Name: _____ Member number #:_____

*** Mobile number used to send SMS reminder before appointment.**

Clinical details

Clinic required:

☐ **Suboxone Therapy** ☐ **Medical Marijuana Recommendations**

Reason for referral / diagnosis:_____

_____

_____

_____

Relevant past history:_____

_____

_____

_____

Please include a list of current medications, any relevant pathology and imaging results with this referral. This information will assist us to appropriately triage your patient.

Referral duration: ☐ 3 months ☐ 12 months ☐ Indefinite ☐ Other_____

Referring doctor details

Name:_____

Address:_____ Email: _____

_____

Telephone number:_____

Fax number:_____

Doctor's signature:_____

Date:_____

Preferred contact: ☐ Telephone ☐ Fax ☐ Email:_____

Office use only

Date received_____ Clinic_____Triage_____