SPECIALTY REFERRAL

Fax to Centralized Scheduling at (606) 408-6816
or call 1-877-304-1935

KING'S DAUGHTERS

Patient Name:_____ Date of Referral: _____

Date of Birth: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Alternate Phone: _____

Email: _____

INSURANCE INFORMATION *Please include a copy of the patient's insurance card(s).*

Policyholder's Name:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other: _____

Policyholder's DOB: _____ Primary Phone #: _____

Primary Insurer:_____Policy #_____Group #_____Effective Date:_____

Secondary Insurer: _____Policy #_____Group #_____Effective Date:_____

Primary Diagnosis: _____ ICD-10 Code: _____

REFERRAL TO:

- ☐ AIMS (Advanced Illness Management)
- ☐ Allergy Services
- ☐ Audiology
- ☐ Bariatrics (Surgical Weight Loss)
- ☐ Behavioral Health (Outpatient)
- ☐ Breast Surgery*
- ☐ Cardiology*
- ☐ Cardiology/Electrophysiology
- ☐ Cardiology/Structural Heart
- ☐ Cardiothoracic Surgery*
- ☐ Chiropractic
- ☐ Colorectal Surgery
- ☐ Coumadin Clinic*
- ☐ COVID Infusion
- ☐ Dermatology*
- ☐ Diabetes Education*
- ☐ Dietetics*
- ☐ ENT/Otolaryngology*
- ☐ Endocrinology
- ☐ Epilepsy Clinic
- ☐ Family Practice/Primary Care*
- ☐ Gastroenterology*
- ☐ General Surgery*
- ☐ Gynecology*
- ☐ Headache Clinic
- ☐ Heart Failure Clinic*
- ☐ Home Health
- ☐ Hypertension Clinic*
- ☐ Infectious Disease
- ☐ Infusion Center*
- ☐ Interventional Radiology
- ☐ Interventional Spine/Pain Mgmt*
- ☐ Lipid Clinic
- ☐ Nphrology*
- ☐ Neurology
- ☐ Obstetrics
- ☐ Occupational Medicine
- ☐ Occupational Therapy*
- ☐ Occupational Therapy (Pediatric)
- ☐ Oncology/Hematology*
- ☐ Orthopedics/Sports Medicine*
- ☐ Pediatrics*
- ☐ Physical Therapy*
- ☐ Physical Therapy (Pediatric)
- ☐ Podiatry*
- ☐ Pulmonology*
- ☐ Plastic/Reconstructive Surgery*
- ☐ Rheumatology
- ☐ Short-Term Rehab
- ☐ Speech Therapy*
- ☐ Speech Therapy (Pediatric)
- ☐ Sports Medicine*
- ☐ Urology*
- ☐ Vascular Surgery*
- ☐ Weight Loss, medical
- ☐ Weight Loss, surgical
- ☐ Other: _____

**** - Available in multiple locations***

Please indicate provider/location preference, if applicable: _____

Referring Provider's Printed Name: _____

Phone #: _____ Fax #: _____

Provider Signature: _____ Date & Time: _____