Comprehensive Breast Health, LLC
Anna M. Knight, MD

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Phone: (205)544-3141 Fax:(205)530-1131

PATIENT REFERRAL FORM

FAX COMPLETED FORM & RECORDS TO: (205) 530-1131

Company Information:

Facility: _____

Referring Physician: _____ Date: _____

Office Contact: _____ Phone: _____ Fax: _____

Reason for Referral: _____

Patient Information:

Patient Name: _____ Email: _____

DOB: _____ Sex: ☐ Female ☐ Male ☐ Prefer not to say

SSN: _____ Phone: (Primary) _____ (Secondary) _____

Address: _____

City: _____ State: _____ Zipcode: _____

Pharmacy: _____ City: _____ Phone: _____

FILMS FROM: ☐ St. Vincent's ☐ Grandview ☐ Other _____ ☐ None

☐ Mammogram _____ ☐ Ultrasound _____ ☐ Other _____

Aspirin/Blood Thinner: _____ Pacemaker/Electronic Device: _____ Hx of CA: _____

Family Hx Cancer: _____

Insurance Information:

Primary Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Subscriber Name: _____ Subscriber DOB: _____

Policy Number: _____ Group Number: _____

Please attach medical records with this request: ☐Demographics ☐Physician Notes ☐All Path/Imaging Results (prior 2 yrs.)

Our office will contact the patient to schedule the appointment and fax back this form to your office so that the referring doctor is aware of the appointment date and time. Our office will make 3 attempts to reach the patient and will hold the referral for up to 3 months. The patient will receive a reminder text at least 2 days prior to their appt.

The Patient Listed above has been scheduled with

Dr. _____

Date: _____ Appt Time: _____ Arrival Time: _____