Church Health Eye Care Clinic
NEW PATIENT REFERRAL FORM

Please send referrals via fax to
901-347-1393

Church Health
care for one another

Date _____

Patient Information						
Name: Last	First	MI	Jr. Sr. etc.	**Birthdate:**	**Gender**	
					☐ Male ☐ Female	
Address			**City**		**State**	**Zip Code**
E-Mail			**Mobile Phone**		**Home Phone**	
Preferred Language					**Insurance Status**	
☐ English ☐ Spanish ☐ Other _____					☐ Insured ☐ Uninsured	
Insurance: Insurance Carrier			ID Number		Group Number	

Referring Physician Information	
Office Name	
Phone Number	Fax Number
Referring Physician	Contact Person

Patient Referral Information
Urgency (clinical decision making) ☐ Next Available ☐ Within 1 Week ☐ Within 2-3 Weeks
Diagnosis/Reason for Visit (please attach last exam note and any testing reports associated with the diagnosis)

Appointment Information			
Date	Time	Provider	Patient Notified ☐Y ☐N
Church Health Staff _____ Date _____			