Henry Community Health
PATIENT REFERRAL FORM

Referring Physician:
Date:
Office Contact: Phone: Fax:
Please send patient demographics, copy of Insurance card, pertinent office notes and Imaging reports. An HCH team member will call your patient to schedule the appointment.

Please select appropriate practice for referral:

- **Henry County Cardiology**
  - Fax 765.599.3101
- **Henry County Center for Orthopedic Surgery and Sports Medicine**
  - Fax 765.521.7394
- **Antolin & Benninger Obstetrics/Gynecology**
  - Fax 765.521.1218
- **Surgical Specialists**
  - Fax 765.599.3286
- **Henry County Infectious Disease & Allergy/Immunology**
  - Fax 765.599.3587

Patient Information
Patient Name: DOB:
Address: Phone:
Reason for Referral:
Primary Insurance: Policy number Group number Policy holder and DOB
Secondary Insurance: Policy number Group number Policy holder and DOB

Any testing performed? Yes No
Please fax pertinent office visit before appointment
If Yes, what test(s): Date: Facility:

FOR OFFICE USE ONLY
Appointment Scheduled by:
Date: Time: