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 you patient to schedule the appointment.

PLEASE SELECT THE APPROPRIATE PRACTICE FOR REFERRAL:

- HCH Cardiopulmonary Rehabilitation
  - Fax 765-599-3530
- Henry County Center for Orthopedic Surgery and Sports Medicine
  - Fax 765-521-7394
- Henry Community Health OB/GYN
  - Fax 765-521-1218
- Henry Community Health Surgical Specialists
  - Fax 765-599-3286
- Henry County Infectious Disease & Allergy/Immunology
  - Fax 765-599-3587

Patient Information

Patient Name: DOB:
Patient 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
If yes, what tests? Date: Facility:

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