REFERRAL FORM

CAPE FEAR FOOT CENTER

1919 South 16th Street, Wilmington, North Carolina 28401

DR. CHRISTOPHER C. YOUNG, DPM PHONE: 910- 763-9334 •FAX 910-763-9339

Date Referred:_____

Referred BY_____Phone:_____Fax:_____

Referred TO: _____Fax #:_____

Office Address:_____ Phone #:_____

Patient Name_____ DOB:_____Gender: F / M

Parent's Name (if patient is a minor)_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Patient's Address:_____

Authorization: ☐ Not Required ☐ Requested/Pending ☐ Requested/Obtained Auth #_____

Primary Medical Insurance:_____Subscriber ID#:_____

Secondary Medical Insurance:_____Subscriber ID#:_____

☐ **Reason for Referral (Symptoms of Concern)** (also send related medical records or dictated summary)

Appointment is scheduled with:_____on _____at _____ arrival time

Date faxed to referring clinician: _____

☐ We will contact patient to schedule ☐ Please have patient call to schedule ☐ Please call patient to schedule