Patient Referral Form

Fax to: (828) 274-1825

Date: _____

Instructions: Form to be completed by physician/provider and faxed to WCMS Project Access®. Project Access® will notify your office of the appropriate specialist for referral once the patient has completed the entire screening process and it has been determined that they qualify for enrollment. **As the patient's provider, you agree to see them free of charge.**

1. ___ Patient is only being seen in my practice (no other referral needed) **(complete #1a below then skip to #5)**
   a. **Date and time of next appointment:** _____
2. If outside referral to specialist or other service is needed, please check the appropriate box(es) below:

☐	Acupuncture
☐	Allergy/Asthma
☐	Anesthesiology
☐	Cardiology
☐	Cardiovascular Surgery
☐	Chiropractic
☐	Dermatology
☐	Diabetic Education
☐	ENT
☐	Family Medicine/Primary Care
☐	Gastroenterology PA®
☐	Gastroenterology - WNC-CRCSI Aged 50-75 with a positive FIT
☐	General Surgery

☐	Genetics/Personalized Medicine
☐	Hematology/Oncology
☐	Infectious Disease
☐	Internal Medicine
☐	Nephrology
☐	Neurology
☐	Neurosurgery
☐	Obstetrics & Gynecology
☐	Ophthalmology
☐	Optometry
☐	Orthopedic Surgery
☐	Pathology
☐	Pediatrics
☐	Physical Medicine & Rehabilitation

☐	Physical Therapy
☐	Plastic Surgery
☐	Psychiatric
☐	Pulmonary Diseases
☐	Radiation Oncology
☐	Rheumatology
☐	Sleep Disorder
☐	Urology
☐	Wound Care
☐	Lab Services
☐	**Counseling (circle below):** Mental Health (diagnosis): Substance Use Developmental Disability

Other Specialty:	Diagnostic (describe):	Radiology (describe):

3. ☐ Urgent need (patient needs appt. within 2 – 5 weeks)
4. Referral reason: _____
5. Primary care provider's name:_____ Phone:_____
6. Patient has: ☐ diabetes ☐ hypertension **6.a If Patient has diabetes, please provide HbA1C:_____**
7. **Patient information:** Name_____ ☐ Interpreter required

   Gender: ☐ Male ☐ Female ☐ Other SS#: _____ Race: _____

   DOB_____ Primary Phone_____ Alternative Phone_____

   Mailing Address:_____

   Other important info:_____
8. **Provider Information:** Signature_____ MD/DO/PA/NP

   Printed Name_____

   Practice Name_____ **Phone:** _____

   Office Contact Name_____ **Fax:** _____