

 3250 Gordonville Road, Suite 450

Cape Girardeau, MO 63703

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 Robert Gardner, MD David Lee, MD Robert Gardner Jr, MD

**Referral Form**

Date: Email:

Patient Name:

Full Legal Name as it appears on Driver’s License or ID

DOB: SSN:

Address:

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sec Ph#:

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:

Physician Preference:

□ Dr. David Lee □ Dr. Gardner, Jr. □ Dr. Gardner, Sr.

Appointment Type: □ Consult □ EMG/NCS

Reason for Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: Phone #:

Address: Fax #:

\*Please send copy of insurance cards, last office notes, and medication list with this referral form and we will contact the patient with the appointment. Thank you for your referral.

□ Request to be notifed of appontment date & time

**Office Use Only:**

Referred To:

Appt. Date: Time: am/pm