Augusta Health Care for Women Referral Form

39 Beam Lane, Fishersville, Virginia 22939
Phone #: 540-213-7750
Fax #:540-213-7755

Referring Physician Practice: Patient records must be attached, please send at minimum (as applicable):

-Record from last office visit
-Lab & Pathology results
-Demographics Print out (ins, etc) or list below
- Imaging/Test results
- Operative Notes

Patient Information:

Patient Name:_____ DOB: ___/___/___

Home Phone:_____ Alternate Phone:_____

Address:_____City:_____ Zip:_____

Preferred Provider:

□ Ami M. Keatts, MD
□ Daniel B. McMillan, MD
□ Molly J. McQuigg, MD
□ Dane M. Larsen, MD
□ Virginia A. Baker, MD
□ Other _____
□ First Available

Urgency of Appointment:

□ Emergent (3-5 days)
□ Urgent (7-10 days)
□ Chronic (2-6 weeks)
□ as deemed appropriate
□ Other _____

Patient's Diagnosis: _____

Patient's Symptoms: _____

_____

Insurance Information: (policy holder information) PLEASE FAX A COPY OF THE INSURANCE CARD

Name:_____ DOB: ____/____/____ SS#:_____

Relationship to Patient_____

Name of Primary Insurance Carrier & Address_____

_____

Name of Secondary Insurance Carrier & Address _____

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