SURGICAL specialists OF CHARLOTTE

To obtain an appointment for your patient with Surgical Specialists of Charlotte, please complete sections 1 and 2 of this form.

☐ Additional documentation attached. Number of pages: _____

1. Referring Provider Information:

Today's Date: _____ Prepared By: _____

Referring Practice: _____

Referring Practice Phone: _____ Fax: _____

Referring Provider: _____ NPI #: _____

Requested Physician: 1: _____ or 2: _____

No Physician Preference: ☐ Requested Location: _____

Diagnosis/ Complaint: _____

2. Patient Information: Please provide demographic sheet

Patient's Name: _____ DOB: _____

Guardian's Name: _____ Relationship: _____ DOB: _____

Preferred Phone #: _____ Alternate #: _____

Patient's Address: _____

Patient's Email: _____

Primary Language (if not English): _____

Insurance Company: _____

Subscriber ID #: _____ Authorization #: _____

Choose Location:

Charlotte | Fort Mill | Huntersville | Matthews | Mint Hill | Pineville | Rock Hill

Once finished, please fax this form along with a demographic sheet and any pertinent information to **704.364.8105**. **We will contact the patient, schedule an appointment, and then fax tracking information back to you for your records.**

APPOINTMENT INFORMATION: (To be completed by Surgical Specialists of Charlotte)

Date of appointment _____ @ _____ AM / PM Patient notified: Y N

Surgical Specialists of Charlotte Physician: _____ Scheduler: _____

SSC Office Location: _____

Phone: (_____) _____ Fax: (_____)_____

Thank you for the opportunity to participate in the care of your patient! **If you have any additional questions, please call 704.364.8104.**