Carolina Pilonidal Center

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NEW PATIENT REFERAL FORM

Patient information:

- Name: _____
- DOB: _____
- Age: _____
- Gender: _____
- Address: _____
- Best contact phone numbers: Home: _____Cell: _____

Insurance Information: (copy and fax both sides of the card)

- Insurance provider: _____
- Policy holder's name: _____
- Policy holder's DOB: _____
- Policy number: _____
- Group number: _____
- Expiration date: _____
- Medicaid referral authorization number (if applicable): _____

Referral information:

- Consultant requested: Dr. George Wadie, MD, Carolina Pilonidal Center
- Reason for referral: _____
  _____
  _____

Referring provider information:

- Name of the provider: _____
- Name of the practice: _____
- Office phone: _____
- Office fax: _____
- Best contact person (referral coordinator): _____

Fax the following information along with this form:

- Copy of insurance card – both sides
- Clinical records: office visits, investigations (labs and radiology) and growth chart.