



PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP
REFERRAL REQUEST



- | | | |
|------------------------------------------------|---------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> JOHN E. NICHOLS, M.D. | <input type="checkbox"/> EDWARD D. TARNAWA, M.D. | <input type="checkbox"/> KATHRYN SNOW, M.D., M.H.A. |
| <input type="checkbox"/> JOHN F. PAYNE, M.D. | <input type="checkbox"/> KARENNE FRU, M.D., Ph.D. | <input type="checkbox"/> VICTORIA BISHOP, FNP-BC |
| <input type="checkbox"/> TRAVIS W. McCOY, M.D. | <input type="checkbox"/> LISA M. COOKINGHAM, M.D. | <input type="checkbox"/> FIRST AVAILABLE |

please select desired location

- | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> GREENVILLE
17 Caledon Court
Suite C
Greenville, SC 29615
P: (864) 232.7734
F: (864) 232.7099 | <input type="checkbox"/> SPARTANBURG
1330 Boiling Springs Road
Suite 2200
Spartanburg, SC 29303
P: (864) 583.2669
F: (864) 583.2459 | <input type="checkbox"/> ASHEVILLE
76 Peachtree Road
Suite 210
Asheville, NC 28803
P: (828) 210.8284
F: (828) 350.7516 | <input type="checkbox"/> COLUMBIA
2324 Sunset Blvd.
W Columbia, SC 29169
P: (803) 726.3600
F: (803) 929.0504 | <input type="checkbox"/> LOWCOUNTRY
5500 Front Street
Suite 410
Summerville, SC 29486
P: (843) 881.7400
F: (843) 881.7444 |
|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|

source of referral

DATE _____
REFERRING PHYSICIAN _____
PRACTICE NAME _____
PRACTICE PHONE _____
PRACTICE FAX _____
PRACTICE EMAIL _____

patient demographics

PATIENT NAME _____
DATE OF BIRTH _____
HOME ADDRESS _____
PATIENT PHONE _____
PATIENT EMAIL _____

reason for referral

- | | | |
|-------------------------------------------------|---------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> INFERTILITY | <input type="checkbox"/> SURGICAL CONSULT | <input type="checkbox"/> SEMEN ANALYSIS |
| <input type="checkbox"/> FERTILITY PRESERVATION | <input type="checkbox"/> RECURRENT PREGNANCY LOSS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> PCOS | <input type="checkbox"/> HSG | |

insurance information (please attach a copy of card if available)

DIAGNOSIS CODE(S) _____ SUBSCRIBER DOB _____
COMPANY _____ SUBSCRIBER ID _____
GROUP NUMBER _____ INSURANCE CONTACT _____
SUBSCRIBER NAME _____ REFERRAL OR PRE-CERT# _____

**Please fax all pertinent medical records to the requested office.*