PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP

REFERRAL REQUEST

- ☐ JOHN E. NICHOLS, M.D.
- ☐ JOHN F. PAYNE, M.D.
- ☐ TRAVIS W. McCOY, M.D.
- ☐ EDWARD D. TARNAWA, M.D.
- ☐ LISA M. COOKINGHAM, M.D.
- ☐ KATHRYN SNOW, M.D., M.H.A.
- ☐ KATHRYN IMGRUND, M.D.
- ☐ VICTORIA BISHOP, FNP-BC
- ☐ FIRST AVAILABLE

please select desired location

☐ **GREENVILLE**
17 Caledon Court
Suite C
Greenville, SC 29615
P: (864) 232.7734
F: (864) 232.7099

☐ **SPARTANBURG**
1330 Boiling Springs Road
Suite 2200
Spartanburg, SC 29303
P: (864) 583.2669
F: (864) 583.2459

☐ **ASHEVILLE**
76 Peachtree Road
Suite 210
Asheville, NC 28803
P: (828) 210.8284
F: (828) 350.7516

☐ **COLUMBIA**
2324 Sunset Blvd.
W Columbia, SC 29169
P: (803) 726.3600
F: (803) 929.0504

☐ **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

- ☐ INFERTILITY
- ☐ FERTILITY PRESERVATION
- ☐ PCOS
- ☐ SURGICAL CONSULT
- ☐ RECURRENT PREGNANCY LOSS
- ☐ HSG
- ☐ SEMEN ANALYSIS
- ☐ OTHER

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

DIAGNOSIS CODE(S) _____
_____
COMPANY _____
GROUP NUMBER _____
SUBSCRIBER NAME _____

SUBSCRIBER DOB _____
SUBSCRIBER ID _____
INSURANCE CONTACT _____
REFERRAL OR PRE-CERT# _____

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