



PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP

REFERRAL REQUEST

- | | | |
|---|--|--|
| <input type="checkbox"/> JOHN E. NICHOLS, M.D. | <input type="checkbox"/> JOHN F. PAYNE, M.D. | <input type="checkbox"/> TRAVIS W. McCOY, M.D. |
| <input type="checkbox"/> EDWARD D. TARNAWA, M.D. | <input type="checkbox"/> J. GRAHAM THEISEN, M.D., MSCR | <input type="checkbox"/> KATHRYN IMGRUND, M.D. |
| <input type="checkbox"/> VICTORIA BISHOP, MSN, FNP-BC | <input type="checkbox"/> HALEY POLLACK, MSN, WHNP-BC | <input type="checkbox"/> SARA BOYD, MSN, WHNP-BC |
| <input type="checkbox"/> RANI KHAN, DNP, FNP-C, CNM | <input type="checkbox"/> MADISON BROWNING, MSN, FNP-C | <input type="checkbox"/> FIRST AVAILABLE |

please select desired location

- | | | | | | |
|---|---|---|---|---|--|
| <input type="checkbox"/> GREENVILLE | <input type="checkbox"/> SPARTANBURG | <input type="checkbox"/> ASHEVILLE | <input type="checkbox"/> COLUMBIA | <input type="checkbox"/> SUMMERVILLE | <input type="checkbox"/> MT. PLEASANT |
| 17 Caledon Court
Suite C
Greenville, SC 29615
P: (864) 232.7734
F: (864) 232.7099 | 1330 Boiling Springs Rd.
Suite 2200
Spartanburg, SC 29303
P: (864) 583.2669
F: (864) 583.2459 | 76 Peachtree Road
Suite 210
Asheville, NC 28803
P: (828) 210.8284
F: (828) 350.7516 | 2324 Sunset Boulevard
W Columbia, SC 29169
P: (803) 726.3600
F: (803) 929.0504 | 5500 Front Street
Suite 410
Summerville, SC 29486
P: (843) 881.7400
F: (843) 881.7444 | 180 Wingo Way
Suite 103
Mt. Pleasant, SC 29464
P: (843) 277.0053
F: (843) 277.0315 |

source of referral

patient demographics

DATE _____	PATIENT NAME _____
REFERRING PHYSICIAN _____	DATE OF BIRTH _____
PRACTICE NAME _____	HOME ADDRESS _____
PRACTICE PHONE _____	_____
PRACTICE FAX _____	PATIENT PHONE _____
PRACTICE EMAIL _____	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 _____
_____	SUBSCRIBER ID _____
COMPANY _____	INSURANCE CONTACT _____
GROUP NUMBER _____	REFERRAL OR PRE-CERT# _____
SUBSCRIBER NAME _____	

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