**Referral Request Form**

To: Amit Patel, MD Bhakti Paul, MD From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 c/o **NRE Referral Coordinator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total # Pages Including Cover: \_\_\_\_\_\_\_\_\_\_

Fax Number: **919-847-5699** Sender’s **FAX** Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: **919-844-6218** Sender’s **PHONE** Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

 Demographic Sheet  Insurance  Office Notes  Lab Results  Imaging

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip Code \_\_\_\_\_\_\_

Patient Main Contact #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Routine  Urgent (24-48 hours)**

** Location Preferred (circle one): North Raleigh or Wake Forest**

** THYROID / NODULES  DIABETES CONSULT  OSTEOPORSIS  CALCIUM DISORDER**

** PITUITARY  HYPOGONADISM  ADRENALS  OTHER:**

**NOTES/REASON FOR CONSULT:**