# Adult Specialist Request

VIDANT HEALTH

**OPTIONS TO REQUEST AN APPOINTMENT:**

- ☐ **Direct Messaging/EHR:** Referral@Direct.VidantHealth.com
- ☐ **P2P eClinicalWorks**
- ☐ **Fax:** 252-847-3337 **Phone:** 252-847-0097
- ☐ **Urgent**

Please include complete office notes including labs and the physician referral note. If you have a stat appointment request, it is best to call the physician's office directly. For emergencies, send the patient to the closest Emergency Department.

**Referral** _____ **MRN #** _____

**Referring office** _____ **Referring office phone** _____

**Office contact** _____ **Contact's fax** _____

**Contact's email** _____ **Direct message address** _____

**Referring provider** _____ *Circle* **MD DO NP PA** **NPI #** _____

**For PAs and NPs – supervising physician** _____ **NPI #** _____

**Faxed on** _____ **Requested specialty** _____

☐ **First available** **OR** **Requested provider** _____

**Preferred Location/Satellite Choice** _____

**Please explain reason for the referral/diagnosis** _____

**Please check the box for any diagnostic test already performed:**

- ☐ **MRI** ☐ **ECHO**
- ☐ **PFT** ☐ **CT**
- ☐ **X-Ray** ☐ **OTHER**

**Location where test was performed:**

_____

_____

_____

**Patient name** _____ **Patient birth date** _____

**Patient address** _____

**City** _____ **State** _____ **Zip** _____

**Gender** ☐ **Male** ☐ **Female** **Race** _____ **SSN** _____

**Home phone** _____ **Alternate phone** _____

**Preferred language** ☐ **English** ☐ **Spanish** ☐ **Other** _____ ☐ **Translator needed**

**Insurance:** ☐ **BCBS** ☐ **Medicare** ☐ **Medicaid** ☐ **Medicaid CA** ☐ **Tricare Prime*** ☐ **Tricare Select**

☐ **Self-pay** ☐ **Other** _____

**Primary insurance #** _____ **Group #** _____

**Secondary insurance** _____ **Group NPI for authorization** _____

**Dates covered** _____ **# Visits covered** _____

**Additional Notes**

**(To Be Used by Specialist Office):**

_____

_____

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***Appointment will not be scheduled until Tricare Prime, Gateway & BCBS Medicare HMO authorization is received***

## REFERRAL SERVICE USE ONLY

| | |
|---|---|
| **Appointment date** _____ | **Appointment time** _____ |
| **Specialist name** _____ **MD DO NP PA** | |

**Office name** _____ **Phone** _____ **Fax** _____

**Office address** _____

**Patient Notified by:** ☐ **Phone** ☐ **Specialty Office** ☐ **VM** ☐ **NVM** ☐ **Mail** ☐ **New patient**