

Baptist Health HealthLine Referral Sheet

Clinic Name: _____

Clinic Address: _____

Contact Name: _____ Clinic Phone: _____ Clinic Fax: _____

_____ Date

_____ Primary Care Physician

_____ Patient Name

_____ Insurance Company Name

_____ Patient Address

_____ ID Number

_____ City State Zip

_____ Group Number

_____ Phone Number

_____ Insurance Company Name

_____ Date of Birth

_____ ID Number

_____ Social Security Number

_____ Group Number

_____ Pre-Authorization #

_____ Diagnosis or Diagnosis Code

_____ Test(s) Ordered/Tests to Be Ordered (Circle)

_____ Speciality _____ Specialist _____ Phone _____ Fax

_____ Special Instructions _____ Routine _____ Urgent

Please Fax Medical Records with Referral or Physician Order for Exam.

Baptist Health HealthLine Use Only

_____ Appointment Date _____ Time AM PM _____ Specialist _____ Facility

_____ Address

_____ Specialty _____ Specialist _____ Phone _____ Fax

_____ Special Instructions _____ Routine _____ Urgent

(2) _____ Exam Date _____ Time AM PM _____ Department _____ Facility

Patient Notified YES NO Patient Made/To Make Appointment _____

_____ Date Completed _____ Notes/Instructions Given

Please fax this form to (501)202-7771. For Question call 227-8478 B-A-P-T-I-S-T, 7am-7pm.