Baptist Health HealthLine Referral Sheet

(Please fill out as completely as possible)

Clinic Name: _____

Clinic Address: _____

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

Is this MVA? _____ Yes _____ No

Date

Patient Name

Patient Address

City State Zip

Phone Number Secondary Number

Date of Birth

Social Security Number

Diagnosis or Diagnosis Code (If Applicable)

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

Specialty Specialist

Primary Care Physician

Insurance Company Name

ID Number

Group Number

Insurance Company Name

ID Number

Group Number

Pre-Authorization #

Physician Authorization Signature

Phone Fax

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

Baptist Health HealthLine Use Only

Appointment Date Time AM PM Specialist Specialty

Address Facility

Phone Fax Routine Urgent

Special Instructions Date Completed

Notes/Instructions Given

Please fax this form to (501)202-7771. For questions call B-A-P-T-I-S-T (227-8478), 7am-5pm.