



Referral / New Patient Inquiry

**Please complete the following and return along with records via fax at 706-353-2205.
Thank you for your referral.**

**Dr. Layher Dr. Lowman Dr. Neckman Dr. Ouzts Dr. Shah
Dr. Willis Dr. Chappell Dr. Avelar**

Patient Name _____ DOB _____

Address _____

Home # _____ Cell # _____

Referring Physician & NPI _____

Reason for Referral/Visit _____

Primary Insurance _____

(Please send copy of card if available)

ID # _____ Group # _____

Secondary Insurance _____

ID # _____ Group # _____

If HMO, POS, GBHC or other plans requiring referral please fax referral

Please provide the following:

- Current Office Note**
- Most Recent Lab Work**
- Echocardiogram Results**
- EKG**
- Exercise Stress Test Results**
- Nuclear Stress Test Results**
- CT Scan Results**
- Carotid – Vascular Study Results**