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DUKE UNIVERSITY HOSPITAL
DUKE UNIVERSITY HEALTH SYSTEM

PHYSICIAN REFERRAL FORM

Box 3808 DUMC
Durham, NC 27710

All patient information below is required to schedule a radiology procedure.
Appointments will be rescheduled if adequate information is not received from the referring physician.
To Schedule, call 919. 684.7999 Fax Referral Forms to 919. 684.7171

MRN / SS# ______________________ Date of Birth ______________________

Name ______________________ City of Birth ______________________

Address ____

City ______________________ State ________ Zip ______________

Home Phone # ______________________ Work Phone # ______________________

Employer ____

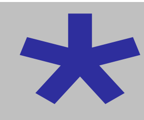
Scheduled Test Date / Time ______________ Location of appointment ______________

Known Drug Allergies ____

Primary Care Physician ______________ Phone # ______________________

Referring Physician (**PRINT** first name, middle initial, last name) ______________________

Phone # ______________________ Fax # ______________________



REFERRING PHYSICIAN SIGNATURE REQUIRED

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SERVICES WILL NOT BE PROVIDED WITHOUT PHYSICIAN'S SIGNATURE

IF PATIENT IS A CHILD, THE FOLLOWING PARENT / GUARDIAN INFORMATION IS REQUIRED:

Name ____

Mailing Address ____

City ______________________ State ________ Zip ______________

Date of Birth ______________________ Social Security Number ______________

Employer ______________________ Work Phone # ______________________

PLEASE CALL TO SCHEDULE APPOINTMENT FOR THE FOLLOWING EXAMS
To Schedule, call 919. 684.7999 Fax this Referral Form to 919. 684.7171

Place an **X** next to the appropriate study.				
		CT		Nuclear Medicine
		GI		Pediatrics
		GU		PET
		Mammography		Ultrasound
		MRI		Vascular / Neuro
		Nuclear Cardiology		Other ______________

Procedure Requested ____

Diagnosis / Reason for Procedure ______________________________

Authorization # ____

To Schedule, call 919. 684.7999 **Fax orders to 919. 684.7171**

Insurance Information

Company ______________________________

Address ______________________________ Phone # ______________

Certificate # (usually SS#) ______________ Group # ______________

Subscriber's Name ______________________ Relation to Patient ____________

Subscriber's Employer ___________________ Subscriber's Date of Birth________

Medicare / Medicaid Information

Name as it appears on your Medicare / Medicaid card ______________________

Your claim identification # ______________________________

Effective Date (Medicare part B at bottom of the card) ______________________

What state issued your Medicaid card ______________________________

Do you have Carolina Access? No or Yes (please circle one)

Champus / HealthNet Information

Name as it appears on your military ID card ______________________________

Military sponsor's name ______________________________

Relationship to patient ______________________________

Sponsor's Social Security # ______________________________

Branch of Service ______________________ DEERS enrolled No or Yes

Duty status ______________________ Pay Grade ______________

If active, Duty Station (Name and Address) ______________________________

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