



URGENT CARE AND HOUSE CALLS REFERRAL REQUEST FORM

**3648 Old Denton Rd Ste 110
Carrollton, Tx 75007
Main Phone : 972-325-5855
Scheduling Department : 214-935-1769 / 972-382-7289
Medication Request : 214-935-1767
Medical Records : 972-332-4126
Fax : 972-492-3600**

Date _____

Referring Provider Information:

Referred by : _____, Medical Group : _____

Phone : _____, Fax : _____ PCP: _____

Address: _____

City: _____ Zip: _____ Gate Code: _____

Patient Information (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____

DOB _____ Gender: Male / Female Phone: _____

Patient's Address: _____

City/State/Zip: _____

Reason for Referral:Diagnosis/ICD-9

Type of Service Requested: _____

Consultation, 2nd Opinion, Radiology Service, Ultrasound, Lab Services EKG Other (please specify)

Reason for Referral:

_____ **Documentation**

Required (please fax with this form)

- **Proof of Insurance.**

Urgent care and House calls accept Medicare, Medicaid and other insurance, We can see patients within 24 to 72 hours.