

VIRA

Vascular & Interventional
Radiology Associates
OF CENTRAL GEORGIA



Medical Solutions for the 21st Century

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Thank you for your referral to our practice. We ask that you please forward the following records including the LAST OFFICE NOTE, X-RAY REPORTS, DEMOGRAPHIC SHEET and a COPY OF ALL INSURANCE CARDS. Please complete and return this referral sheet along with the requested information and we will call your office with an appointment. Thank you for your cooperation.

REFERRAL SHEET

Patient's Name: _____ DOB: _____

Address: _____

Patient's Phone: _____ Work Phone: _____

Patient's SS#: _____ Martial Status: _____

Primary Ins: _____ Group #: _____

Id#: _____

Secondary Ins: _____ Group#: _____

Id#: _____

Reason for Referral: _____

Referring Physician Name: _____ Contact: _____

Address: _____

Phone: _____ Fax: _____

OFFICE USE ONLY

Appointment Date: _____ Time: _____

** Please have patient bring a copy of the disc or films with them to their appointment **