Rutland Women's Healthcare

A Department of Rutland Regional Medical Center

REFERRAL FORM

Date of Referral: _____

Patient's Name: _____ D.O.B: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Referring MD: _____

Fax: _____ Phone: _____

Required Information

Primary Insurance Carrier:_____ Group #: _____

Policy #: _____ Subscriber: ❒ Self ❒ Spouse ❒ Other

Diagnosis/Reason for Appointment: _____

Previous visit w/ (check one): ❒ Ananda Boyer, MD ❒ Thusitha Cotter, MD ❒ Sarah Decker, MD
❒ Robin Leight, MD ❒ Kira Wozmak, MD ❒ Sarah Bache, APRN, WHNP-BC

Office Visit Request:

❒ First Available

❒ Referral to (check one): ❒ Ananda Boyer, MD ❒ Thusitha Cotter, MD ❒ Sarah Decker, MD
❒ Robin Leight, MD ❒ Kira Wozmak, MD ❒ Sarah Bache, APRN, WHNP-BC

Please attach with this completed referral form, last office visit notes, lab results, US / CT reports, last Pap results, Medical History, Medication list and any other documentation pertinent to this referral.

Note: Labs and diagnostic testing done at Rutland Regional after 3/1/2011 are available to us through the electronic medical record (EMR).

➔ FAX THIS REFERRAL REQUEST TO 802.775.1974 ←

****FOR RWH USE ONLY****

Appointment Date & Time: _____ Contact Date: _____ by: _____

Patient contacted by: ❒ Phone ❒ Mail (letter sent): _____ ❒ Answering machine

WKST #4264 Created 12/11 Rev
6/12, 8/12, 10/12, 5/13, 9/14, 11/15,
1/17, 12/17, 7/19, 10/19

Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Patient Label