Rutland General Surgery

A Department of Rutland Regional Medical Center

Referral Form

Name: ________________________________ DOB: ______________ AGE: ___________

Address:____

Preferred Phone:_________________________________

Primary Insurance Name: _____________________________ Policy #____________ Group #________

Secondary Insurance Name: ___________________________ Policy #____________ Group #________

PLEASE PROVIDE PERTINENT OFFICE NOTES, LABS, X-RAY REPORTS AND MEDICATION LISTS

DIAGNOSIS/REASON FOR VISIT: ____

Must be included to schedule appointment.

Referring MD:____

Fax #:____________________________________Phone#:

Primary Care Physician:____

(If different than referring provider listed above)

❑ **First Available** or **Specific Provider:** ❑ M. Conway, MD ❑ A. Dudzik, MD ❑ M. Hurtado, MD ❑ B. Jimmo, MD ❑ Wound Care/B. Canfield, NP

Service Appointment Requested (choose one): ❑ Urgent ❑ Routine

Special Needs: (Wheelchair, transfer assist, etc.) ________________________________

Appointment Preferences: Day of Week_____________________________ ❑ AM ❑ PM

Please complete and fax referral form to 802.775.5503

Patient Label