



METABOLIC CLINIC REFERRALS GREENWOOD GENETIC CENTER

Please send/fax all pertinent medical records including laboratory results, radiology reports, newborn discharge summaries, developmental records, along with this form.

For appointments in Greenwood or Greenville
Toll Free: 1-866-479-4363
Fax: 1-864-371-6910

For appointments in Columbia, Florence or Charleston
Toll Free: 1-877-679-0927
Fax (toll free): 1-866-676-9881

Date of Referral: _____ Person making referral: _____

Referring Physician or Agency/Office: _____

Address: _____ Phone: _____ Fax: _____

Patient Name: _____ Male/Female
(First) (Middle) (Last)

Patient's DOB: _____ SS#: _____ Interpreter-Yes (Language _____)/No

Parent/Guardian: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Home: _____ Work: _____ Cell: _____

Primary:
Insurance Company: _____

Secondary:
Insurance Company: _____

Policy #: _____

Policy#: _____

Authorization #: _____

Authorization #: _____

REASON FOR REFERRAL: _____

SIGNATURE OF REFERRING PHYSICIAN

Greenwood Genetic Center will contact the patient to schedule the appointment and will notify the referring office with the appointment information.

Date of Appointment: _____ Time: _____ Clinic: _____

CONFIDENTIALITY NOTICE: The information contained in this fax message is legally privileged and confidential information. This information is intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this information is strictly prohibited by federal regulation. **IF YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY BY TELEPHONE AT THE NUMBER LISTED ABOVE OR THE GREENWOOD GENETIC CENTER AT (864) 941-8100.**