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: _____

Policy #: _____

Authorization #: _____

Secondary:
Insurance Company: _____

Policy#: _____

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: _____
