Referral Form
Fax to (336) 293-4857
Phone: (336) 245-8320
2554 Lewisville-Clemmons Rd, suite 308
Clemmons, NC 27012

Date: _____

Patient name: _____ DOB: _____

Reason for Referral:** _____

Phone (home):_____ (cell):_____ (work):_____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____

Email: _____

Pharmacy: _____

Primary Insurance: _____

Subscriber ID:_____ Group #: _____

Subscriber Name: _____ DOB: _____

Secondary Insurance: _____

Referring Office: _____ Group NPI#_____

☐ Urgent ☐ Next available

**Please attach pt. demographics and last clinic note pertaining to referral.*

***Routine Eye Exams only for pts. 10yrs old and younger, unless special need exists.*

TPEP Office Use Only

SCHEDULED:_____ **TIME:** _____

Checklist:

_____ Enter info into Health Fusion/Meditouch

_____ Invite to Portal /do paperwork within portal 100%

_____ Send Welcome Email

_____ Inform referring office

Contact Attempts:

1. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____
2. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____
3. Date:_____/_____/____ at _____ am / pm
   Phone #: Type of Contact:
   (____)_____-_____ _____
   (____)_____-_____ _____