LANCASTER ENDOCRINOLOGY REFERRAL FORM
Robert Wozniak, MD

Please *check* preference for location:

____**Rock Hill Office**	_____**First Available**	_____**Charlotte Office**
Herlong Professional Park		Hunters Crossing
410 S. Herlong Ave. Ste 106		16147 Lancaster Hwy. Ste 140
Rock Hill, SC 29732		Charlotte, NC 28277
Ph: 803-329-3899		Ph: 704-544-3166

Fax all referrals to: 704-544-3164

****Please fill out this form COMPLETELY. Our system will not let us proceed if information is missing. Thank You!!!****

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____Zip_____

DOB _____ SS#: _____ Circle: Male Female

Home Ph# _____ Cell # _____ Work# _____

Primary Ins. _____Phone _____ID _____

Secondary Ins._____ Phone_____ ID_____

Subscriber Information (If not patient)

Name _____ SS# _____ DOB _____ Relationship_____

*******Please fax insurance referral and/or authorization with form*******

Consultation requested by:

Physician _____ UPIN _____ NPI _____

Address_____

Practice Name_____ Phone _____ Fax _____

Reason for Referral _____

WE WILL NOT BE ABLE TO SCHEDULE AN APPOINTMENT UNTIL THE FOLLOWING INFORMATION IS RECEIVED

- **LAST 2 OFFICE NOTES AND LABS**
- **MRI, CT, THYROID SCAN OR THYROID ULTRASOUND REPORT**
- **LEGIBLE COPY OF INSURANCE CARD (FRONT & BACK)**

Disclaimer: Patients are to discuss the potential seriousness of their diagnoses as well as the importance of a prompt follow up with their referring doctor. Patients must also verify with their provider if the timeframe of the scheduled appointment is acceptable. In order t**o expedite the** visit, medical records are required preceding the scheduled time; note, however, that they are *not* reviewed by the physician prior to the appointment date. As such, Lancaster Endocrinology® will not be held liable for analyzing the urgency of the referral in question. A review of the medical records will be conducted by the physician only at the time of the visit.

Appointment Date &Time _____

Provider _____ Location _____