PROVIDER REFERRAL FORM

HORIZON EYE CARE

DATE: _____

REFERRAL PRIORITY REQUEST
- ❑ Emergency - Please Call Horizon
- ❑ Urgent - Within 7 Days
- ❑ Next Available Appointment

LOCATION REQUESTED
- ❑ Cotswold
- ❑ Huntersville
- ❑ Mallard Creek
- ❑ Mooresville
- ❑ Pineville
- ❑ Waverly

HORIZON PHYSICIAN REQUESTED:

_____

❑ Please Fax Appointment Confirmation

Referring Provider Information (Required)

Name: _____ NPI# _____

Practice Name: _____

Address: _____

Provider's Email: _____

Phone: _____ Direct Fax: _____

Patient Information (Required)

❑ **ATTACH DEMOGRAPHIC SHEET** ➡ Attach Demographic Sheet only if **all** patient's personal information as listed has been provided. **Please make sure all of the information as requested is provided.**

Patient Name: _____

Patient Address: _____

Phone #1: _____ Phone #2: _____

D.O.B.: _____ Primary Insurance: _____

Language: _____ Race: _____ Ethnicity: _____ Gender: ❑ Female ❑ Male

Reason for Referral/Consult: _____

_____

_____

Diagnosis: _____

_____

Additional Remarks: _____

_____

Please include only the exam notes pertinent to this appointment with this fax. Number of pages attached: _____

THIS SECTION TO BE COMPLETED BY HEC STAFF AND WILL BE RETURNED TO YOUR PRACTICE, TO THE FAX NUMBER YOU PROVIDED.

Appointment Date: _____ Time: _____

Provider: _____ Location: _____

PROVIDER REFERRAL LINE

PHONE: 704-367-8138 **FAX:** 704-405-4091

To ensure this patient's appointment can be made please complete this form.
All information must be clearly identified and we will contact your patient for an appointment within 48 hours.
We will notify you of their appointment if a fax number is provided.