SURGICAL CLINIC
ASSOCIATES

Referral Request Form

Phone 601-948-1411
Fax 601-948-0090

501 Marshall St. Suite 500
Jackson, MS 39202

Date: ______

Please fill in all requested data below and FAX with relevant clinical notes and a copy of the insurance card.

Referral to:

- ☐ G. Edward Copeland, MD
- ☐ Erin R. Cummins, M.D.
- ☐ James R. Rooks, M.D.
- ☐ Gina E. Heath, M.D.
- ☐ Andrew C. Mallette, M.D.
- ☐ Nathan D. Maples, M.D.
- ☐ Jason G. Murphy, M.D.
- ☐ Logan D Fair, M.D.
- ☐ Sara B. Parker, M.D.

Referring M.D.: ______

Reason for Referral: ______

DX: ______

Patient Information: Male ☐ Female ☐ **DOB:** ______

Name: ______

Address: ______

Cell Phone: ______ **Home Phone:** ______ **Work Phone:** ______

Insurance Information: (Please send copy of card)

Insurance Plan: ______

Insurance ID: ______ **Group:** ______

Insurance Address: ______

Subscriber: ______ **Subscriber DOB:** ______

Requires Authorization? Yes ☐ No ☐ **Auth #** ______

Please fax with all the following information to 601-948-0090

- ☐ All pathology reports
- ☐ Radiology Reports
- ☐ Pertinent progress notes
- ☐ Pertinent lab results
- ☐ Copy of Insurance card

Prefill electronically, print, and fax with the required records.