



**HEP C CLINIC - PATIENT REFERRAL FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ SS#: \_\_\_\_\_

Insurance: \_\_\_\_\_ Contract#: \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Referral (*insurance referral authorizations should be faxed with this request*):

- Evaluation and treatment of Hepatitis C

**\*\*Please send patient demographics, insurance information (including referral authorization if needed) along with current H&P, labs, radiology reports, most recent office note including screening results and any other pertinent clinical information.**

Referring Physician's Printed Name: \_\_\_\_\_

Referring Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

***To refer a patient to the EAMC Hepatitis C Clinic:***

- 1. FAX referral with patient information to Clinic (334) 528-5311**
- 2. Call Clinic to SCHEDULE patient appointment: (334) 528-HEPC(4372)**

*Thank you for choosing the EAMC Hepatitis C Clinic  
Located on the campus of East Alabama Medical Center*

*2000 Pepperell Parkway, Building 190 - Opelika, AL 36801 - (334) 528-HEPC (4372)*