



New Patient Referral Form
Ferrell-Duncan Clinic Branson General Surgery
 525 Branson Landing Blvd., Suite 307
 Branson, MO 65616

Phone: 417-348-8080 Fax: 417-335-4002

REFERRING CLINIC INFORMATION	Date:
Referring Clinic Name:	Clinic Contact Name:
Referring Provider Name:	
Phone:	Fax:

PATIENT INFORMATION	
Patients must be age 18 or older	
Patient Name:	Patient Date of Birth:
Home Address:	
Home Phone:	Cell Phone:
Work Phone:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (Specify):
Primary Language:	Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Name:	Contact Relationship:
1 st Insurance:	Policy: Group:
2 nd Insurance:	Policy: Group:
Is this a Work Comp related injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please complete and fax referral to Work Complete at 417-269-2668	
Employer Name/Contact information:	

REFERRAL INFORMATION	
<input type="checkbox"/> First Available Physician	Specific Physician requested (if applicable):
Select one of the following: <input type="checkbox"/> Office consult <input type="checkbox"/> EGD <input type="checkbox"/> Colonoscopy	
Diagnosis/Complaint:	
Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury/Symptoms:
This form must be completed and faxed with the following:	
1) All office notes pertaining to the diagnosis/reason for referral	
2) Any labs and diagnostic testing/imaging pertaining to the diagnosis/reason for referral	
3) Patient medication list	
4) Copy of patient's insurance card(s) including front and back and valid photo ID	

Fax this completed form to: 417-335-4002

The patient will be scheduled as soon as possible and we will notify you of the appointment date and time.
 Appointments will not be scheduled until all records are received.

OFFICE USE ONLY

Appointment Information:

Provider: _____ Date: _____ Time: _____
 Patient notified: Yes No _____ Staff Initials: _____