Medical Arts Building ● 350 Park Street, Suite 203
Bowling Green, KY 42101
Phone: (270) 781-0075 ● Fax: (270) 781-0143
Toll Free: 1-866-997-5784
www.WomensHealthSpecialists.net

REFERRAL REQUEST

To facilitate a smooth referral process, please fill out this form completely, and send to our office along with a copy of the patient's insurance card(s) (if available) and any information pertaining to the reason for referral (i.e. lab results, diagnostic test results, office visit notes, etc.). We will then work with the patient to find a date/time that best suits her schedule, to be seen by our providers at their desired location.

Patient Name: _____

Patient Date of Birth: _____ **Phone:** _____

Address: _____

_____

Insurance: _____

Referring Provider: _____

Office Phone: _____ **Office Fax:** _____

Office Contact: _____

Reason for Referral: _____

_____

----------WHS Office Use Only----------

Appointment Date / Time: _____

WHS Provider: _____

Comments: _____

_____

Revised 4/2015