SOUTH COVE COMMUNITY HEALTH CENTER

Sent From: ☐ 145 South Street, Boston, MA 02111, Tel (617) 521-6730, Fax (617) 457-6696 ☐ 88 Holmes Street, Quincy, MA 02171, Tel (617) 318-3230, Fax (617) 318-3292

PATIENT REFERRAL

Date: _____

Patient Name (Last, First, MI): _____

Referred to (Facility): _____
Department/Specialty: _____
Telephone #: _____
Fax #: _____
Patient Hospital #: _____
Provider: _____
Provider Plan #: _____

SCCHC Medical Record #: _____
Date of Birth: _____/_____/_____
Address: _____
_____
Telephone #: _____
Insurance Name: _____
Insurance #: _____
Referral Authorization #: _____

OTHER INFORMATION NEEDED:

Preferred Day: M___ Tu___W ___ Th___ F___Sat___
Preferred Time: AM ____ PM ____
Shuttle/Taxi requested: Yes ____ No ____
APPOINTMENT: Date: _____ **Time:** _____

Translator Requested? Yes _____ No_____
Language: Cantonese____ Mandarin____ Vietnamese____
Mandatory follow-up visit at SCCHC is required:
Yes _____ When: _____ Appointment: _____

REASON FOR REFERRAL:

Patient Diagnosis: _____

Provider Name (Print): _____ Signed/ Title: _____
Department: _____

ACTION REQUIRED:

_____ Return WHITE copy of this referral and/or a copy of case notes for our records in the mail or electronically.
_____ Keep the YELLOW copy.
_____ This is a managed care patient. We are authorizing _____visits beginning_____.
Call _____at: (Circle One) *Quincy* Dental (617) 318-3230; or *South St. Dental (617) 521-6730*
for authorization if additional referrals are required.

REPORT OF REFERRAL:

Provider Name (Print): _____ Signed/ Title: _____

WHITE: Return Copy; **YELLOW:** Referral Source; **PINK:** SCCHC Medical Records

Reviewed and revised: 10/31/13