

Specialty Service Referral General Surgery

SBL Surgery Clinic
1000 Health Center Dr., Suite 401 • Mattoon, IL 61938
217-258-4040 • Fax 217-258-4023



REFERRING PROVIDER

Name _____ Phone _____ Fax _____
Reason for Referral _____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____
Address _____ City _____ State/Zip _____
Phone _____ County _____
Insurance Carrier Primary _____ Secondary _____
If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____
Work Related Yes No If yes, Employer _____ Contact _____
Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- Provider Notes Appropriate Laboratory Reports Medication and Allergy Lists
 Procedure Reports Appropriate Imaging Reports

Required Procedures for Referral

Please have the referring provider obtain these procedures prior to the referral appointment.

- Breast Patients — Mammogram with Ultrasound (if needed) and/or Ultrasound Guided Biopsy (if needed)
- Vascular Patients — Arterial Doppler
- Dialysis Patients — Rounding Report and Operative Report (if done outside Sarah Bush Lincoln)

Cardiologist Yes No Provider _____
Pulmonologist Yes No Provider _____
Last Colonoscopy Date _____ Where Performed _____

REFERRING RESPONSE

- Patient Scheduled
Provider _____ Date _____ Time _____
Comment _____
- Patient NOT Scheduled
Additional Information Required _____
Other Reason _____