Lexington Clinic

1221 South Broadway
Lexington, Kentucky 40504
859.258.4DOC (4362)

REFERRAL FORM

Please fax this form and the required information to 859.258.6118.
For DERMATOLOGY referrals, please fax to 859.254.1814.
For questions regarding this form, please contact us at 859.258.4DOC (4362).

Name of Medical Practice _____

Address _____

Contact Person _____ **Phone** _____ **Fax** _____

Referring Physician _____ **LC Reference #** _____
full name and title

KY License Number _____ **NPI** _____

Department Requested _____ **Provider Requested** _____
(optional)

Reason/DX _____

Preferred time of day ☐ AM ☐ PM **Preferred day of week** _____

Appointment time requested ☐ 1 week ☐ 1 month ☐ 1st available ☐ ASAP *(emergencies only)*

Please include all office notes, labs and imaging reports pertaining to this referral

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Patient Name _____ **LC MRN#** _____

DOB _____ **Age** _____ **SSN** _____ ☐ Male ☐ Female

Address _____

City _____ **State** _____ **Zip code** _____

Home phone _____ **Cell phone** _____

Insurance _____
Please include insurance company, plan and member ID #

Please send a copy of insurance card along with the fax form.

Cardholder Name _____ **DOB** _____

For referral services use only

Appointment Date & Time _____ Provider Name _____

Comments _____

_____

_____

_____ New to Lexington Clinic _____ New to Department _____ Updated Demographics

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Does this insurance require prior authorization? ☐ Yes ☐ No *If yes, please obtain using the following information.*

Phone _____ Fax _____

NPI _____ Tax ID # _____