

Referral Form

Person referring patient office: _____

Phone number: _____

Demographics (Patient Information)

Patient Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

SSN#: _____

Emergency Contact: _____

Patient Diagnosis: _____

Physician Information

Ordering Physician: _____

Phone Number: _____

Primary Care Physician: _____

Phone Number: _____

Equipment

Equipment the physician is ordering:

*If Oxygen...need a sat reading: _____

*If Sleep...need a sleep study: _____

Insurance Information

Primary Insurance: ID# _____ Group # _____

Secondary Insurance: ID# _____ Group # _____

**Please complete this form and fax to Vantage Central Intake at 814-337-8641 or 1-866-251-7838. Please remember to attach a copy of the script for the order. An Intake Specialist will call you to confirm this order. Thank You!