Geriatric Medicine Clinic at UAB Hospital-Highlands
New Patient Referral Form

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apartment/Unit #: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Mobile Phone: _____ Email: _____

Social Security: _____ Date of Birth: _____

Insurance Company & Contract Number: _____

Reason for Referral (check one box): ☐ Consult Care ☐ Primary Care

Problem/Diagnosis: _____

Referring Provider Information:

Provider Name: _____ Provider NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____

Fax Information:

Fax the following to 205-996-2733

- 3 last hospital discharge notes and 3 last lab results
- Hospital discharge notes for the past 6 months
- Radiology results for past year