

Specialty Service Referral Obstetrics & Gynecology

SBL Women's Healthcare
Sarah Bush Lincoln Health Center
1000 Health Center Dr., Suite 201 • Mattoon, IL 61938
217-258-4030 • Fax 217-258-2353



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
- ☐ Procedure Reports
- ☐ Appropriate Laboratory Reports
- ☐ Appropriate Imaging Reports
- ☐ Medication and Allergy Lists

Please indicate specialty needed for referral.

Preferred Provider _____

Appointment Urgency

- ☐ First available
- ☐ Urgent

REFERRING RESPONSE

- ☐ Patient Scheduled

Provider _____ Date _____ Time _____
Comment _____

- ☐ Patient NOT Scheduled

Additional Information Required _____
Other Reason _____