Collom & Carney Clinic ASSOCIATION

**** *Consult / Referral Forms are now available on-line at www.cccahealth.com* ****

5002 Cowhorn Creek Drive
Texarkana, Tx. 75503
Phone: (903) 614-3002
Fax: (903) 614-3504

# PEDIATRICS

☐ **CONSULT** (Request for advice / opinion) **or** ☐ **REFERRAL** (Request for management of care)
**(Please only select one request)**

## REQUESTING PROVIDER INFORMATION

| Requesting Provider Name | Requesting Provider Address (street, city, state, zip) |
|---|---|
| | |

| Requesting Provider Telephone | Requesting Provider Fax Number | NPI # |
|---|---|---|
| ( ) - | ( ) - | |

## APPOINTMENT REQUEST

☐ **First Available** ☐ **R. Clark Green, MD** ☐ **Christina Payne, MD** ☐ **Mark Wright, MD**
☐ **Cheryl Saul-Sehy, MD** ☐ **Zach King, MD** ☐ **Cindy Porter, MD** ☐ **Cheryl Kite, NP**
☐ **Susan Droske, NP**

## DIAGNOSIS

## PATIENT and INSURANCE INFORMATION

| Patient Name (First, Middle Initial, Last) | Gender |
|---|---|
| | ☐ Male ☐ Female |

| Address | City, State, Zip |
|---|---|
| | |

| Date of Birth (mm/dd/yyyy) | Social Security # |
|---|---|
| / / | - - |

| Home Telephone | Mobile Telephone | Work Telephone |
|---|---|---|
| ( ) - | ( ) - | ( ) - xtn |

| Does patient need an interpreter? | If yes, what language? |
|---|---|
| ☐ Y ☐ N | |

| Does the patient have medical insurance? | Name of Insurance Company and Plan Number and Group Number |
|---|---|
| ☐ Y ☐ N | |

## DOCUMENTATION

*Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3504.*
*Thank you in advance for the consult request and your cooperation.*