Patient Referral Form (already enrolled pts)

Date: _____

Fax to: (828) 274-1825

Instructions: Form to be completed by physician/provider and faxed to WCMS Project Access®. Project Access® will notify your office of the appropriate specialist for referral within 2 business days. **As the patient's provider, you agree to see them free of charge.**

This form is only for patients who are already enrolled in Project Access®, but need a new outside referral (patient will not go through the screening process). If your patient will be new to Project Access® or needs to be re-enrolled in the program, please use the full Patient Referral Form.

1. **Patient information:** Name_____

   DOB_____ SS#: _____

2. **Provider Information:** Signature_____ MD/DO/PA/NP

   Printed Name_____

   Practice Name_____ Phone_____

   Office Contact Name_____ **Fax**_____

3. For outside referral to specialist or other service, please check the appropriate box(es) below:

	Acupuncture
	Allergy/Asthma
	Anesthesiology
	Cardiology
	Cardiovascular Surgery
	Chiropractic
	Dermatology
	Diabetic Education
	ENT
	Family Medicine/Primary Care
	Gastroenterology
	General Surgery
	Hematology/Oncology
	Infectious Disease

	Internal Medicine
	Nephrology
	Neurology
	Neurosurgery
	Obstetrics & Gynecology
	Ophthalmology
	Optometry
	Orthopedic Surgery
	Pathology
	Pediatrics
	Physical Medicine & Rehabilitation
	Physical Therapy
	Plastic Surgery
	Psychiatric

	Pulmonary Diseases
	Radiation Oncology
	Rheumatology
	Sleep Disorder
	Urology
	Wound Care
	Lab Services
	Counseling (circle below):
	Mental Health (diagnosis):
	Substance Use
	Developmental Disability

Other Specialty:	Diagnostic (describe):	Radiology (describe):

4. Referral reason: _____

5. Specific provider or practice requested: _____

   (PA staff will try to honor any requests for a particular provider, but cannot guarantee the request depending on the number of patients that provider has pledged to see)