The Community Health Clinic

730 E North Street
Shipshewana, IN 46565
Phone: (260) 593-0108
Fax: (260) 593-0116

New Patient Referral

Total Pages including Cover: _____ Today's Date: _____

Please complete this form and fax it along with all pertinent medical records (progress notes, lab results, genetic testing, imaging studies, etc.). Records not required if accessible in Epic.

Referring Provider: _____ Type: _____
Referring Provider Phone #: _____ Fax #: _____

Patient's Name: _____ Date of Birth: _____
SSN: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____ Cell #: _____
Parents' Names: _____
Mother's maiden name: _____ Date of birth: _____

Reasons for Referral (check all that apply):

☐ Developmental Delays ☐ Seizures ☐ Birth defects: _____

☐ Intellectual disability ☐ Family history of genetic condition: _____

☐ Failure to thrive/growth concerns ☐ Dysmorphic features: _____

Has your patient had a previous genetic workup?: ☐ Yes ☐ No

If "yes," Doctor/Facility Name: _____
Results of genetic workup: _____
_____

If "no," which genetic condition(s) is suspected: _____
_____

*** Please notify your patient that **the Community Health Clinic is SELF-PAY ONLY** and payment is due at the time of the visit. Insurance can be billed for any outside testing/labs***

Primary Insurance: _____ Secondary Insurance: _____

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