The Community Health Clinic

315 Lehman Avenue, Suite C
PO Box 9
Topeka, IN 46571

New Patient Referral

Attention: Debbie Howell, MA

From: _____

Fax #: (260) 593 – 0116

Fax Number: _____

Phone Number: (260) 593-0108

Phone Number: _____

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). We gather all possible medical records on new patients prior to scheduling there appointment.

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Primary Insurance: _____ Secondary Insurance: _____

Reason for Referral: _____

_____

Diagnosis: _____ ☐ Suspected ☐ Confirmed

Previous Genetic Work-up: ☐ Yes ☐ No

☐ Doctor Referral

Referring Provider: _____

Referring Provider Phone #: _____ Fax #: _____

☐ Self/Child Referral

Primary Care Physician: _____ Phone #: _____