



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 #: _____

Confidentiality Notice: The documents accompanying this fax transmission may contain confidential information. The information is intended only for the use of the individual(s) or entity named above. If you are not the intended recipient, you are notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this fax information is not permissible. If you have received this fax in error, please immediately notify us by telephone at the above number and then destroy the fax information. Thank you!