Global Healthcare Systems, Inc

PRIMARY CARE REFERRAL FORM

Complete this form to refer patients to Global Primary Care Clinic

Fax form to: **(410) 296-1687**

Attention: Global PCP Medical Director

PATIENT INFORMATION

Patient Name: _____ DOB_____ Gender: M__ F__ SS#_____

Home Phone Number: _____ Cell Phone Number: _____

If patient is a Minor, Parent/Guardian _____ Contact #_____

Patient Address: _____ Patient's Email_____

List past & current Diagnosis(es) *(if known*): _____

REFERRING STAFF INFORMATION

Name of Referring Agency: _____
Print Name and Title of Referring Staff: _____
Signature: _____Date of referral: _____
Contact Phone#: _____ Fax #:_____

If the appointment is made via phone PLEASE COMPLETE this section:

Date and Time of Patient's Appointment: _____

Appointment made by: (Name of Primary Care Clinic Staff) _____

PLEASE COMPLETE ALL THAT APPLY

1. Insurance Type: Medicaid #_____Medicare#_____

Aetna #_____ United Healthcare#_____ Other insurance_____

2. Primary Care Provider (PCP) (Check One):
_____No PCP _____I have PCP but want to switch to Global Primary Care Clinic

Name of current PCP (if known): _____ PCP Phone#_____

Reason for requesting change of PCP: _____