



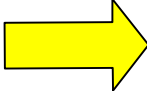
South Carolina OB-GYN Associates, P.A.  
 1333 Taylor Street, Suite 2-D | Columbia, SC 29201  
 (803) 254.1300 or 799.BABY

[www.scobgyn.com](http://www.scobgyn.com) Email: [scobgyn@hotmail.com](mailto:scobgyn@hotmail.com)

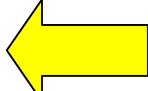
**I Need an Appointment With...** (Please circle your physician preference)

DAVID H. POSTLES, JR., M.D.	JAMES W. STANDS, M.D.	M. TUCKER LAFFITTE, III, M.D.
MARK H. SALLEY, M.D.	DAVID C. HOLLADAY, M.D.	THOMAS P. GIUDICE, M.D.
ROBERT P. GRUMBACH, M.D.	REBECCA B. RIDENHOUR, M.D.	

**Please fax back this form along with the following information:**



- Office notes pertaining to referral
- Labs, or other pertinent reports
- Clear copies of insurance cards
- Insurance referral if necessary



**PLEASE FAX TO (803) 771-7597**

**Appointment Time-Frame** (Please Circle One)

 **STAT** (MD must speak with MD)
 **With In 1 Week**
 **I<sup>st</sup> Available Appt**

Please schedule the below patient for an appointment with **Dr.** \_\_\_\_\_

**FROM:** \_\_\_\_\_  
(Referring Provider's Name) (NPI #) (Practice's Name)

*Patient's Name:* \_\_\_\_\_ *Pt's Ph:* (H) \_\_\_\_\_ (W) \_\_\_\_\_

*Pt's Insurance:* \_\_\_\_\_ *Pt's SSN:* \_\_\_\_\_ *DOB* \_\_\_\_\_

*Problem / Remarks:* (Please send pertinent medical records and copy of most current insurance card)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
(Nurse, or Contact Person Requesting Appointment)

\_\_\_\_\_  
(Contact Person's Phone #)

**THANK YOU FOR REFERRING YOUR PATIENT TO SC OB-GYN, P.A.**