



www.scobgyn.com

Email: scobgyn@hotmail.com

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

JAMES W. STANDS, M.D.

MARK H. SALLEY, M.D.

DAVID C. HOLLADAY, M.D.

M. TUCKER LAFFITTE, III, M.D.

THOMAS P. GIUDICE, M.D.

ROBERT P. GRUMBACH, M.D.

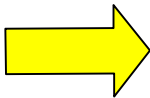
REBECCA B. RIDENHOUR, M.D.

CHRIS HUTCHINSON, M.D.

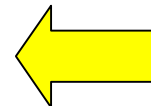
MARY NEUFFER, M.D.

COURTNEY BROOKS, 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 note, we do not accept Medicaid)



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

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

★ **STAT** (MD must speak with MD)

★ **With In 1 Week**

★ **1<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.**

