SOUTH CAROLINA OBGYN ASSOCIATES

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*** ★ ***1st 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.