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Coffeyville, Ks 67337  
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## **PATIENT REFERRAL FORM (General Surgery)**

Please CALL OUR OFFICE to schedule an appointment for the patient.

Complete this form and fax along with records, most recent office progress notes, labs work, imaging or any testing pertaining to patient symptoms.

Date: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Referring Provider Phone: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

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For CRMC Medical Group

\_\_\_\_\_  
Date of Appointment

\_\_\_\_\_  
Time

AM / PM