GRANTS PASS SURGICAL ASSOCIATES P.C.

1600 NW 6th St., North Suite
Grants Pass, Oregon 97526
Phone 541-474-5533
Fax 541-476-2380

REFERRING OFFICE INFORMATION

Surgeon you wish your patient to see _____

Referring physician _____ PCP _____

Office contact name _____ Title _____

Office phone _____ Office fax _____

PATIENT INFORMATION

Patient name _____

DOB _____ SS# _____

Address _____

Home phone _____ Work phone _____

Cell phone _____

REASON FOR REFERRAL

Patient's symptoms/diagnosis _____

Diagnostic test performed (CT, MRI, etc.) _____

HEALTH INSURANCE *Please attach a copy of patient's insurance card(s).*

Primary insurance _____ Secondary Insurance _____

Policy ID# _____ Policy ID# _____

Name of subscriber _____ Name of subscriber _____

Group# _____ Group# _____

PATIENT APPOINTMENT

Patient is scheduled for an appointment with Dr. _____

Date _____ M T W Th F Time _____

☐ Please notify patient of their appointment. ☐ Clinic packet has been mailed.

****Please have patient hand-carry their X-rays.****