



# Asheville Endocrinology Consultants

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## New Patient Referral Form

Fax To: (828) 667-2198

Referring Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ For Confirmation

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ eMail: \_\_\_\_\_

Insurance:  Medicare  Medicaid  BlueCross  Cigna Other: \_\_\_\_\_

\*Note-we participate with most insurance companies **EXCEPT** United HealthCare Commercial Plans. We will advise if we do not.

 **Please Send a Clear Copy of Insurance Card(s)** 

Diagnosis:  Diabetes Last A1C Results: \_\_\_\_\_  Other: \_\_\_\_\_

Hypothyroidism  Hyperthyroid (Need Medical Records to Determine Urgency)

Osteoporosis (Last Bone Density, Vitamin D)

 **Please Fax Last 2 Office Visits and Last 2 Lab Reports** 

Thank you for your referral! The patient will be sent a new patient letter and map.

AEC Use: Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician: \_\_\_\_\_