# *Referral to Western Wake Wellness*

401 KEISLER DRIVE
SUITE 101
CARY NC 27518
919-378-1492
www.WesternWakeWellness.com

**PATIENT INFORMATION**

Last Name:_________________________________________ First Name: ___________________________ MI: ____

Today's Date: ______/______/_________ Date of birth:______/______/_________ Legal Sex: ☐ Male ☐ Female

Street Address:___________________________________ City:____________________ State:______ Zip:_________

Home Phone:____________________ Cell Phone:_____________________ Language: ☐ English ☐ Other:_________

Patient's Email Address:______________________________________________________________________________

**APPOINTMENT REQUEST INFORMATION**

Provider Requested: _________________________________________________________________________________

Appointment Timeline: ☐ Urgent (Less than 3 days) ☐ 4-14 Days ☐ Routine (establish PCP care) ☐ Other:_________

Chief Complaint and Diagnosis (ICD-10): _________________________________________________________________

**PRIMARY HEALTH INSURANCE INFORMATION**

Insurance Company:_________________________________________________________________________________

Policy Holder's Name:______________________________________________ Relationship to Patient:____________

Policy Holder's Date of birth:______/______/_________ Employer/Group Name:________________________________

Policy ID#:________________________ Group#:______________________ Effective Date: ______/______/_________

**SECONDARY INSURANCE**

Insurance Company:_________________________________________________________________________________

Policy ID#:________________________ Group#:______________________ Effective Date: ______/______/_________

**REFERING PROVIDER INFORMATION** ***(FOR SELF-REFERRAL, USE LAST PCP)*****:**

Practice Facility Name:_______________________________________________________________________________

Provider Name / Address: _____________________________________________________________________________

Provider Phone: __________________________________ Provider Fax: ____________________________________

Person Completing Request: __________________________ Phone for Questions: _____________________________

***Office Use Only***

APPOINTMENT SCHEDULED WITH: _______________ on Date: ______/______/_________ at ______:_______ a.m. / p.m.

☐ Could not reach patient ☐ Left voicemail message ☐ A letter was mailed to the patient ☐ Patient declined

☐ Unable to communicate with patient due to: ___________________________________________________________