M. TAMER YALCINKAYA, M.D. CAROLINAS FERTILITY INSTITUTE, P.A.

Phone 336-448-9100

REFERRAL INTAKE FORM

Fax 336-778-7995

To streamline scheduling your patient for a visit, please complete this form, which will enable us to see your patient in a timely manner. Please fax the completed form to 336-778-7995, along with the office notes, ultrasound and lab reports, we will call the patient with the appointment time. Feel free to call with any questions. Please complete this form as much as possible to avoid delays in scheduling your patient.

If you already have a form with this information on it, please fax it with the office notes, ultrasounds and lab information. Thank you for your help.

Patient Name			Phone
Address			
DOB Emergency Contact		Ok to leave message at home re: appts? (Y or N) Phone	
Primary Insurance	e (Attach Ins Card	or Complete)	
Telephone Number:			
Insurer Mailing Addro	ess		
Relationship to Patien	t:		
Subscriber ID#		Group #	
Referring MD		Office Contact Person	Phone
Diagnosis		_	Allergies?
Reason for Visit or Pro	ocedure Requested		
For CFI use only:			
Employee's name/date	of referral		
Insurance Coverag	ge Notes:		