PATIENT REFERRAL INSTRUCTIONS

Patients must be referred by a medical professional. No self-referrals will be accepted.
The patient must have a primary care physician. No exceptions, please.

Please find enclosed the following forms:

- ❑ Referral/Patient Information Form
- ❑ Verification of Financial Information
- ❑ Authorization to Release Healthcare Information

These forms need to be filled out completely.

For the **Referral Form**, the form must be completed in entirety including the **Procedure/ Consultation** the patient needs. Surgery on Sunday prefers for your primary care doctor to complete this form. However, the referring agency may also complete.

For the **Authorization to Release Healthcare Information**, the form must be completed in entirety. Please list your name, birth date, social security number and maiden name, if applicable. Be sure to sign and date the bottom.

For the **Verification of Current Income** you must include a copy of financial records for all household members. Examples include, 2 months of pay stubs or prior year W2 statement. If you are currently unemployed and receiving benefits please submit a copy of your benefit statement(s).

Completed forms should be submitted to:

Surgery on Sunday, Inc.
533 Waller Avenue
Lexington, KY 40504
P 859.246.0046
F 859.246.1752

Surgery on Sunday℠

Changing Lives One Surgery at a Time

REFERRAL/PATIENT INFORMATION FORM

What procedure/consultation does the patient need? _____

_____

Last: _____ First: _____ MI: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ SS#:_____ Gender: ❒ M ❒ F

Race: _____ Interpreter needed: ❒ Yes ❒ No If yes, language:_____

Phone: _____ Cell: _____

Email: _____ Preferred method of contact: _____

If under 18, parent/guardian name: _____

Next of kin: _____ Phone: _____

Relationship: _____

May we leave a message on the phone numbers provided?_____

Who, other than you, may we discuss your medical information with?_____

_____

REFERRAL AGENCY INFORMATION

PATIENT TRIAGE LEVEL: ❒ URGENT ❒ REQUIRED

REFERRAL AGENCY: _____

REFERRAL CONTACT: _____

ADDRESS: _____

EMAIL: _____ CITY: _____ STATE: ____ ZIP:_____

REFERRAL FAX: _____ PHONE: _____

Signature of Medical Professional: _____ DATE: _____

MEDICAL CONDITIONS/HEALTH HISTORY:

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

MEDICAL INFORMATION

Have you ever applied for a medical card? _____ Date applied: _____

Have you ever applied for disability? _____ Date applied: _____

Status of disability application: _____

Do you have a known disability? ❒ Yes ❒ No What is the disability? _____

Patient height: _____ Patient weight: _____ BMI: _____

BMI must be 35 or lower

Primary care physician: _____

Address: _____ Phone: _____

Who will be taking you to your surgery? _____

Relationship: _____ Phone: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's name: _____ Date of birth: _____

Previous name: _____ Social Security #: _____

I request and authorize _____

(Name of Hospital or Doctor's Office where you have been seen)

to release healthcare information of the patient named above to:

Name: **Surgery On Sunday**
533 Waller Avenue
Lexington, KY 40504

This request and authorization applies to:

❒ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

❒ All healthcare information

❒ Other: _____

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❒ Yes ❒ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❒ Yes ❒ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

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VERIFICATION OF FINANCIAL INFORMATION

NOTE: *Household income includes spouse, domestic partner and other persons living in the house.*

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Procedure: _____

Marital Status: _____ Living Situation (Rent/Own/Homeless): _____

How many Reside in Household? _____

Household Annual Income: _____ ***(Please provide 2 months of Pay Stubs or W2)***

Employment Status: _____ Insurance Status: _____

Please indicate which benefits below your household receive. ***For any listed, please provide a copy of each award statement.***

Unemployment	$ _____Month
Workers' Compensation	$ _____Month
Social Security	$ _____Month
Disability	$ _____Month
Child Support	$ _____Month
Supplemental Nutrition Assistance Program	$ _____Month
Kinship Care	$ _____Month
State Supplementation	$ _____Month
Medical Assistance	$ _____Month
Alimony	$ _____Month

I certify that the information contained in this form is true and correct to the best of my knowledge.
Withholding information regarding assistance is fraudulent and is subject to penalties.

Patient Signature: _____ Date Signed: _____

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