Primary Care Medical Center, PLLC

15444 Dedeaux Road, Suite B
Gulfport, MS 39503
Phone: (228) 832-9038 Fax: (228) 832-9990
Email: primarycaregulfport@gmail.com

REFERRAL SELECTION FORM

PATIENT NAME	SSN	DATE
PLEASE VERIFY YOUR INSURANCE		

YOU ARE BEING REFERRED TO **ANOTHER PROVIDER** TO MEET YOUR CURRENT HEALTHCARE NEEDS.

CHOOSE ONE OF THE TWO OPTIONS BELOW:

☐ 1. We will select a provider in your insurance network for you.

☐ 2. You may select the provider by completing the information.

Provider: Name_____Phone Number_____

Your information will be faxed to your new provider and a staff member should contact you to set up your appointment within one week. If you have not received a call from the referral office within the week, we recommend that you call their office to schedule your appointment. You may also call our office and we will be happy to assist you with your appointment.

YOU ARE BEING REFERRED TO HAVE A **PROCEDURE** COMPLETED.

CHOOSE ONE OF THE TWO OPTIONS BELOW:

☐ 1. We will select a provider in your insurance network for you.

☐ 2. You may select the provider by completing the information below.

☐ **COMPASS IMAGING**
☐ **GARDEN PARK MEDICAL CENTER**
☐ **MEMORIAL HOSPITAL OF GULFPORT**
☐ **OTHER**_____

MESSAGES

Please call my: ☐ home ☐ work ☐ cell Number: _____ or notify me by email.

My email_____
If unable to reach me: ☐ you may leave a detailed message ☐ leave a message asking me to return your call ☐ send an email

The best time to reach me is (day)_____between (time)_____
I understand that only under normal conditions will I be left any messages or sent any emails.

Dated _____ Signature _____