Metro Surgical Appointment Request Form

Phone: 912.826.4057
Fax: 912.826.2853 or 912.826.0794

PLEASE CHECK THE BOX TO INDICATE WHICH OF OUR PHYSICIANS YOU WOULD LIKE YOUR PATIENT TO SEE:

- ☐ NO PREFERENCE/EARLIEST APPOINTMENT AVAILABLE
- ☐ Dr. John Odom
- ☐ Dr. Mark Blankenship
- ☐ Dr. Anthony Foley
- ☐ Dr. Michelino Scarlata
- ☐ Dr. Ravindra George
- ☐ Dr. Joey Christmas
- ☐ Dr. Priscilla Thomas

Patient Name: ______________________ Patient DOB: ______________________

Contact Number(s): ______________________ Reason for referral: ______________________

Primary/Secondary Insurance(s): ______________________

Insurance ID Number(s): ______________________

Is authorization required to see a specialist? Yes or No

If yes, authorization number: ______________________

Referring Physician: ______________________

Referring Physician Phone: ______________________ Fax: ______________________

1ST Attempt: ______________________

2nd Attempt: ______________________

3rd Attempt: ______________________

Your patient has been scheduled and notified.

Date: ______________________

Time: ______________________

Office Location: ______________________

Demographic information, insurance Card(s), office notes, operative reports, pathology, radiology, labs, and any notes that are pertinent to this appointment must be sent with this form completed in its entirety or it **WILL NOT BE PROCESSED!**