

Serenity Respiratory

Physician Referral Form

Phone: 850-900-7869 ext. 5 | Referral fax: 407-612-2342

Complete this form and fax it with relevant orders and records to 407-612-2342.

Referral is subject to service availability, eligibility review, and any required authorization.

1 PATIENT & PARENT / GUARDIAN

Patient full name

Date of birth

Parent / guardian name

Phone

Home address, city, state and ZIP

2 REFERRING PROVIDER

Provider name and credentials

Practice / facility

Office phone

Office fax

Contact person

3 REFERRAL DETAILS

Reason for referral / relevant diagnosis

Services requested / relevant care orders (attach orders as applicable)

Requested start date / anticipated discharge date, if applicable

4 PROVIDER AUTHORIZATION

Provider signature (sign after printing)

Date

Attach relevant signed orders, clinical notes, and insurance information, as applicable.

Protect patient information. Return the completed form by fax, rather than ordinary email.

2613 Centerville Rd., Tallahassee, FL 32308 | This form is not for emergency requests.