UAB MEDICINE
PHYSICIAN SERVICES & UAB CONNECT

Patient Referral Form

Date: ______________________ **UAB MR#:** ______________________

Referring MD: ______________________ **City/St:** ______________________

Phone: ______________________ **Fax:** ______________________

Office Contact: ______________________

Patient Information:

Name: ______________________ **DOB:** ______________________

SSN: ______________________ **Phone:** ______________________

Address: ______________________

City/St/Zip: ______________________

Insurance: ______________________ **Contract #:** ______________________

Group #: ______________________ **Effective Date:** ______________________

Name on Insurance: ______________________

2nd Insurance: ______________________ **Contract #:** ______________________

Group #: ______________________ **Effective Date:** ______________________

Name on Insurance: ______________________

Diagnosis/Reason for Referral (Required): ______________________

Specialty Requested: ______________________ **UAB MD Requested:** ______________________

Notes: ______________________

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Please return via vax to 205.996.9107 or email to physicianservices@uabmc.edu.
To speak with Physician Services, please call 205.934.6890.
Thank you for choosing UAB Medicine!