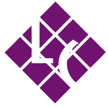

Lexington Clinic

1221 South Broadway | Lexington, Kentucky 40504
859.258.4DOC (4362) | Fax: 859.258.6118
Katrina Kiser, Referral Liaison | resref@lexclin.com

REFERRAL FORM

Please fax this form and the required information to 859.258.6118.
For questions regarding this form, please contact our Referral Liaison, Katrina Kiser.

Name of Medical Practice ____________________

Address ____________________

Contact Person ____________ **Phone** ____________ **Fax** ____________

Referring Physician ____________________ **LC Reference #** ________
full name and title

KY License Number ____________________ **NPI** ____________

Department Requested ____________________ **Provider Requested** ____________________
(optional)

Reason/DX ____________________

Preferred time of day ☐ AM ☐ PM **Preferred day of week** ____________________

Appointment time requested ☐ 1 week ☐ 1 month ☐ 1st available ☐ ASAP *(emergencies only)*

Please include all office notes, labs and imaging reports pertaining to this referral

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Patient Name ____________________ **LC MRN#** ____________

DOB ____________ **Age** ________ **SSN** ____________________ ☐ Male ☐ Female

Address ____________________

City ____________ **State** ____________ **Zip code** ____________

Home phone ____________________ **Cell phone** ____________________

Insurance ____________________
Please include insurance company, plan and member ID #

Please send a copy of insurance card

Cardholder Name ____________________ **DOB** ____________

For referral services use only

Appointment Date & Time ____________________ Provider Name ____________________

Comments ____________________

____

____

________ New to Lexington Clinic ________ New to Department ________ Updated Demographics

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Does this insurance require prior authorization? ☐ Yes ☐ No *If yes, please obtain using the following information.*

Phone ____________________ Fax ____________________

NPI ____________________ Tax ID # ____________________