



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

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

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

Phone _____ Fax _____

NPI _____ Tax ID # 611262927