REFERRAL FORM

PHONE: 850-696-4000

FAX NUMBERS Provided Below

Woodlands Specialty Divisions

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Hematology-Oncology
Fax: 850-607-6507
Alejandro Inclan, M.D.
Jamal Joudeh, M.D.
Rami Owera, M.D.
Shailesh Patel, M.D.
Michael Poiesz, M.D.
John Schaub, D.O.
Ashley Glass-Hooks, APRN
Sherry LeRoy, APRN
Jenny Perez, APRN
Mary Browning, PA-C

Radiation Oncology
Fax: 850-912-4506
Coyt Rountree, M.D.
Nikki Kelley, APRN

Urology / Robotic Surgical Institute
Fax: 850-696-4013
Frank Greskovich, M.D.
Jacques Farhi, M.D.
Ashley King, M.D.
Alexander Liu, M.D.
Brett Parra, M.D.
Davinder Sekhon, M.D.
Jeffrey Wolters, M.D.
Jill Gates, APRN
Alainna (Laini) Gill, APRN
Brent Kiser, APRN
Sean Tolbert, APRN
Larry (Jordan) Williams, APRN
Kaitlyn Tutt, PA-C

Pulmonology
Fax: 850-898-3550
Allison Perkins, D.O.

Breast Health Radiology
Fax: 850-607-7553
Emily Joyce, M.D.
Jessica Miller M.D.
Venetia Vassiliades, M.D.

Diagnostic Imaging
Fax: 850-607-7553
MRI, PET, CT, Ultrasound, X-Ray, Dexa, Echo, Screening and Diagnostic Mammogram, Breast Biopsy, Breast Ultrasound, Breast MRI

Early Detection CT Lung Screening
Lung Navigator
Phone: 850-696-4363

WOODLANDS
MEDICAL SPECIALISTS

Thank you for referring your patient to Woodlands Medical Specialists. Please complete this form and fax to the division of your choice. All fax numbers are noted on the left of this paperwork.

Please include the patient's medical records including clinic/hospital notes, lab work, and any additional information. Once the completed form is received with records, we will fax this form back to you with an appointment date and time. We will be unable to make an appointment without records.

IF NO RECORDS AVAILABLE PLEASE INDICATE WHY: _____

REFERRING PROVIDER: _____

REFERRING PROVIDER MAIN CONTACT: _____

REFERRING PROVIDER PHONE: _____ FAX: _____

PATIENT NAME: _____

PATIENT MAILING ADDRESS: _____

DATE OF BIRTH: _____SSN_____

HOME PHONE: _____ CELL PHONE_____

EMAIL:_____

PRIMARY INSURANCE CARRIER: _____

PRIMARY INSURANCE CONTRACT NUMBER: _____

AUTHORIZATION NUMBER: _____

SUBSCRIBER NAME AND DOB: _____

SECONDARY INSURANCE CARRIER: _____

SECONDARY INSURANCE CONTRACT NUMBER: _____

SUBSCRIBER NAME AND DOB: _____

TERTIARY INSURANCE CARRIER: _____

TERTIARY INSURANCE CONTRACT NUMBER: _____

REASON FOR REFERRAL: _____

REFERRAL TO: _____CLINIC LOCATION: _____

ADDITIONAL INFORMATION: _____

To be completed by Woodlands Medical Specialists

DATE APPOINTMENT FAXED TO REFERRING DOCTOR'S OFFICE: _____ Date

of New Patient Appointment: _____ Time: _____ am/pm Doctor's

Name/Location: _____ WMS

Scheduler: _____

WE WILL CONTACT THE PATIENT WITH APPOINTMENT INFORMATION AND MAIL THE PATIENT AN APPOINTMENT REMINDER CARD WITH NEW PATIENT PAPERWORK TO BE COMPLETED PRIOR TO THEIR VISIT. THANK YOU.

Revised 09/26/24