REFERRAL FORM

PHONE: 850-696-4000
FAX NUMBERS: Provided Below by each Woodlands Specialty Division

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.
Sharon Johnson, APRN
Sherry LeRoy, APRN
Jessica Walsh, 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
Jacques Farhi, M.D.
Frank Greskovich, 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
Jason Bond, PA-C
Kaitlyn Tutt, PA-C

Breast Health Radiology
Fax: 850-607-7553
Amy Coleman, M.D.
Brittany Hermecz, M.D.
Jill Rutherford, M.D.
Jonathan Walter, M.D.

Diagnostic Imaging
Fax: 850-607-7553
Body Composition
Dexa (Bone Density)
Breast Biopsy, US, and MRI
CT
Diagnostic & Screening Mammogram
Echocardiogram
General & Vascular Ultrasound
MRI
Nuclear Medicine
PET/CT
X-Ray

Early Detection CT Lung Screening
Phone: 850-696-4200

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 02/20/26