803 Liberty Road
Flowood, MS
39232

Southern Specialty Clinic

P: 601.714.1967
F: 601.714.1966

New Patient Referral Form

E-mail to scheduling@southernspecialty.org *or* Fax to (601) 714-1966.
For general questions about referrals please contact our office.

REFERRAL INFORMATION

Date of Referral: _____ Is referral urgent*? ☐Yes ☐No

If you feel the referral is of an urgent nature, please contact the office or provider directly to discuss the patient.

Referral to:
- ☐ Pediatric Metabolic Medicine & Weight Management | Callie B. Hall, FNP-C
- ☐ Hematology | Sharon Pennington, MD; Bryce Hughes, PNP
  - ☐ Comprehensive Lifespan Sickle Cell Program
  - ☐ Comprehensive Lifespan Hemophilia/Bleeding and Clotting Disorder Program
  - ☐ Pediatric Benign Hematology

Referral Reason: _____
_____
_____

Included: ☐ Clinical Notes ☐ Imaging Results ☐ Lab Results ☐ Pathology Results ☐ Genetic Testing

Please note referrals without supporting documents will not be scheduled.

REFERRING PROVIDER INFORMATION

Provider Name: _____ Provider Specialty: _____
Clinic Name: _____ Phone: _____ Fax: _____
Clinic Address: _____
Referring Clinic Point of Contact: _____ Phone: _____ Ext: _____
Email: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SSN: _____
Mailing Address: _____
City: _____ State: _____ ZIP Code: _____ Phone: _____
Caregiver (if applicable): _____ Alternate Contact Number: _____

INSURANCE INFORMATION

Primary Insurance: _____ Group #: _____ Plan ID: _____
Subscriber Name: _____ DOB: _____
*MINORS ONLY:
Guarantor (First, Last): _____
Date of Birth: ____ /_____ /_____ SSN: _____ - ____ - _____
Address: _____
Phone #: _____ - _____ - _____

***Please include front and back of insurance cards or demographic sheet.* Without this information, scheduling the patient will be delayed. ***